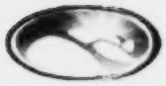

Five Hills Health Region

Healthy Choices - Healthy People

ANNUAL REPORT

to the

Minister of Health
and
Minister of Healthy Living Services

For the 2006-07 fiscal year

2008-06133/

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The Five Hills Health Region annual report is located on the internet at:
www.fhhr.ca

June 15, 2007

The Honourable Len Taylor and The Honourable Graham Addley
Minister of Health Minister of Health Living Services

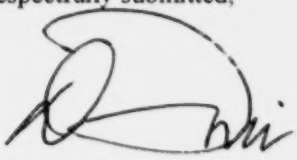
Dear Minister Taylor and Minister Addley,

The Five Hills Regional Health Authority is pleased to provide you and the residents of the health region with its 2006-07 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the region for the year ended March 31, 2007.

2006/07 has been a significant year, with a focus by the region on 10 top strategic priorities. These included community engagement, client centered service, access, primary health care, regional hospital services, quality, safety, population health, recruitment and retention and capital renewal. Many of our achievements have been highlighted in this report.

Our success is directly linked to the hard work and dedication of our staff, physicians, volunteers and communities throughout the region.

Respectfully submitted,



Dale Toni
Chairperson

Who We Are

The Department of Health (Saskatchewan Health) sets out specific directions in the Accountability Document for the prudent and ethical use of public funds. Saskatchewan Health identifies the provincial health system's vision statement and goals in *The Action Plan for Saskatchewan Health Care*:

SASKATCHEWAN HEALTH

VISION

Building a province of healthy people and healthy communities.

GOALS

Improved access to quality health services
Effective health promotion and disease prevention;
Retain, recruit and train health providers; and
A sustainable, efficient, accountable, quality health system.

The Five Hills Regional Health Authority developed a statement of Mission, Vision, Values, Goals and Objectives. While these statements are unique to the Five Hills Health Region, they are consistent with the direction articulated in Saskatchewan Health's Performance Plan.

FIVE HILLS REGIONAL HEALTH AUTHORITY

MISSION

People helping people through quality services, education, teamwork, communication, community engagement and healthy public policy.

VISION

Healthy Choices – Healthy People

VALUES

Respect	Trust
Honesty	Integrity
Accountability	Compassion
Dedication	Inclusion
Teamwork	Diversity
Safety	Quality
Community focus	Patient/client/resident focused
Holistic approach	Evidence-based decision-making

Goal 1: Full Potential for Five Hills Regional Health Authority

The desired priority of Full Potential for Five Hills Regional Health Authority includes but is not limited to the following results:

- Moose Jaw Union Hospital reaches its full potential as a Level 1 Regional Centre
- Community hospitals in Assiniboia, Central Butte, and Gravelbourg reach their full potential.
- A co-ordinated primary health care system.
- Supportive Care services meet the needs of changing urban and rural demographics
- Facilities meet present and future needs.
- Public are confident that services are there when required.
    - People receive timely care in the most appropriate location.
    - Waiting times are reasonable.
    - Public know what services are available and how to access them.
    - Clients understand what may be expected from services offered.

Goal 2: Health Promotion and Disease Prevention

The desired priority of Health Promotion and Disease Prevention includes but is not limited to the following results:

- An effective health promotion and disease prevention initiative
    - Address the determinants of health within our mandate.
- People have sufficient knowledge to enable them to make healthy choices.
    - Well-informed and knowledgeable clients and stakeholders.
- Appropriate community development activities
- Healthy public policies

Goal 3: Human Resources

The desired priority of Human Resources includes but is not limited to the following results:

- Five Hills Health Region is an employer of choice
- Sustainable human resources

Goal 4: A Sustainable Health System

The desired priority of a Sustainable Health System includes but is not limited to the following results:

- Effective, efficient, and appropriate use of resources
- An accountability reporting mechanism
- Relationships with foundations, health care organizations and other stakeholders are well defined and effective

STRATEGIC ALIGNMENT

The Five Hills Health Region has developed a mission, vision, values, goals and objectives that align with the health system strategic direction established by Sask Health. Alignment is also achieved through compliance with our legislative mandate and Accountability Document. The Accountability Document outlines the service and program obligations of the region – through expectations and measures of performance that have been set out by Sask Health.

SERVICE RESPONSIBILITY

The Five Hills Health Region is responsible for acute care, long term care, home care, ambulance services, public health, mental health and addiction services. The region either directly delivers health services – through its staff – or contracts with other agencies for the provision of services. These contracted agencies are referred to as Health Care Organizations and include all private sector, community based and affiliated (religious based) service agencies that provide ambulance, addiction, mental health and long term care and acute services. Health Care organizations are accountable through and to the Five Hills Health Region.

SERVICE LEVELS

Acute Care

Regional Hospital

Moose Jaw Union Hospital is a Tier 1 Regional Hospital with 100 inpatient beds. This hospital provides a range of secondary inpatient acute care services including emergency room, intensive care unit, surgery, surgical suite/recovery, day surgery, medicine, mental health, pediatrics, and women's health. These services are supported by professionals in laboratory, diagnostic imaging, CT, ultrasound, respiratory therapy, hyperbaric, physical therapy, occupational therapy, pharmacy, and central sterile supply.

Community Hospitals

There are three community hospitals located in Assiniboia (17 beds), Gravelbourg (9 beds) and Central Butte (5 beds). These hospitals provide acute inpatient medical care and emergency room coverage with 24/7 RN staffing. Each hospital is integrated with long term care beds, which includes designated respite and convalescent care.

HEALTH REGION FACILITIES (* contracted agencies)								
	Inpatient Days (adult)		Average Daily Census		Percent Occupancy		Average Length of Stay	
	2007	2006	2007	2006	2007	2006	2007	2006
Moose Jaw Union Hospital	27275	26030	74.7	71.3	74.7%	71.3%	5.7	5.4
Central Butte Regency Hospital	1213	1331	3.3	3.6	47.5%	52.1%	11.1	7.7
Assiniboia Union Hospital	3864	4133	10.6	11.3	52.9%	56.6%	8.3	9.2
St. Joseph's Hospital *	2195	2389	6.0	6.5	66.8%	72.7%	4.4	3.8

MOOSE JAW UNION HOSPITAL STATISTICS								
Nursing Unit	Patient Days		Average Daily Census		Percent Occupancy		Average Length of Stay	
	2007	2006	2007	2006	2007	2006	2007	2006
Nursery-Paed Admissions	53	24	0.15	0.15	14.52	14.79	2.52	2.25
Intensive Care Unit	1269	1205	3.48	3.3	69.53	66.03	3.33	3.43
Obstetrics/Women's Health Unit	2136	2105	5.85	5.77	41.8	41.19	2.5	2.43
Paediatrics	1990	2042	5.45	5.59	54.52	55.95	2.44	2.42
Psychiatry	4217	4141	11.55	11.35	82.52	81.04	13.22	12.7
Surgical Units	5278	4892	14.46	13.4	72.3	67.01	4.97	4.62
Medical Units	12332	11591	33.79	31.76	93.85	88.21	9.2	8.64
Total Adult Patient Days	27275	26000	74.73	71.32	74.73	71.32	5.69	5.41
Nursery - Newborn	1027	1146	2.81	3.14	28.14	31.4	2.49	2.55
Total Adult & Newborn	28302	27146	77.54	74.46	70.49	67.69	5.43	5.16

Continuing Care

Continuing Care services are generally provided to a population of frail elderly persons over the age of 75 years. Using a single point of entry for the entire service, the Access Center is an innovative service. Persons in the region wanting assistance to determine an appropriate range of services can call one phone number to obtain access to a range of services.

The continuing care program includes home care nursing, home care personal care, home care acute care replacement services, inpatient geriatric assessment and rehabilitation, long term care, transition, convalescent, respite, palliative, and podiatry. Institutional care is available to over 500 long term care residents, plus 14 geriatric assessment and rehabilitation,

14 transition as well as designated respite and convalescent beds. The majority of institutional long term care support is provided by affiliate organizations, Providence Place, Moose Jaw (160), St. Joseph Hospital/Foyer D'Youville, Gravelbourg (50), and Extendicare/Moose Jaw (127). The region provides long term care services in Rockglen (16), Assiniboia (60), Lafleche (16), Central Butte (22), and Moose Jaw (60).

Community based clients are further supported with day programs located at Providence Place, Central Butte, Assiniboia, and Gravelbourg.

HEALTH REGION FACILITIES
(* contracted agencies)

	Resident Days		Average Daily Census		Percent Occupancy	
	2007	2006	2007	2006	2007	2006
Central Butte Regency Hospital	7804	7541	21.4	20.7	97.2%	93.9%
Assiniboia Union Hospital	8003	7894	21.9	21.6	99.7%	98.3%
Craik and District Health Centre	5585	5331	15.3	14.6	102.0%	97.4%
Ross Payant Nursing Home	13702	13426	37.5	36.8	98.8%	96.8%
LaFleche Health Centre	5747	5285	15.7	14.5	98.4%	90.5%
Grasslands Health Centre	6067	5948	16.6	16.3	97.8%	95.9%
Extendicare *	44832	44278	122.8	121.3	96.7%	95.5%
Pioneers Housing	25918	26589	71.0	72.8	96.0%	98.4%
St. Joseph's Hospital *	17930	17929	49.1	49.1	98.2%	98.2%
Providence Place *	62516	62747	171.3	171.9	98.4%	98.8%

HOME CARE

Nursing Hours of Service		Meals		Homemaking Hours of Service		Individualized Care Contracts	
2007	2006	2007	2006	2007	2006	2007	2006
16305	16383	16199	15064	83985	89154	6	6

Mental Health and Addictions Services

The mental health inpatient unit at MJUH is supported by a well developed regional mental health program and addictions services. Inpatient detoxification services are provided by the Angus Campbell Centre which has a contract with the region for these services.

This service has a centralized intake process. Associated with these services are innovative programs such as Kids First, an integrated school team, and many new initiatives under Project Hope. Most recently, Wakamow Place opened in Moose Jaw as a result of federal, provincial and municipal support. Wakamow Place provides housing, recreational and vocational support for those clients with long term serious mental illness.

Public Health

Under the leadership of the Medical Officer and Public Health Director, Public Health Services provides a range of services and programs, including: public health nursing, public health inspection, child psychology, public health nutrition, epidemiology, dental health education, population health promotion, speech and language, Kids First Community Developers, Teen Wellness Clinic, and Mentoring of Mothers Program.

These broad services are also directed at marginalized populations, such as refugees and new immigrants, and those accessing needle exchange services. Services include response to outbreaks of any type. PHS forms part of the Health Regions emergency response capability.

This service is responsible for maintaining health status reports, and needs assessments, across the age-spectrum of the population.

Primary Health

The shift to a primary health care delivery system based on service provision by integrated, interprofessional teams is making slow progress. The region's first primary health team was established in Central Butte and is an integral part of services provided at the Central Butte integrated facility site. Progress has been made in this area for an integrated primary health approach to providing services. Primary health care is leading development of a project charter for chronic disease management regionally.

The next phase of primary health integration is occurring through a pilot project for Assiniboia with visiting services to Willow Bunch, Mossbank, Rockglen and Kincaid. Positive results to improve the health of the community are being obtained through a well defined community development approach used by the primary health care team in partnership with community members.

Regional Health

Regional services administrative support is highly centralized in Moose Jaw. With over 1400 full time equivalent employees, the region has efficiently centralized services for finance, information technology, payroll, staff development, occupational health and safety, quality of care and risk management, privacy and communications, nutrition and food services, laundry, housekeeping, biomedical engineering, maintenance, capital planning, security, disaster planning, materials management, human resources and labor relations, recruitment and selection as well as related administrative support.

Medical Staff

Specialist areas include: family medicine including ER, orthopedic surgery, ophthalmology, general surgery, urology, anesthesia, radiology, pathology, and internal medicine.

OPPORTUNITIES, THREATS AND RISKS

The Five Hills Regional Health Authority adopted an ***enterprise risk management approach*** in late 2004/05. The Quality Improvement Unit of the Five Hills Health Region has been designated as the risk management committee for the organization. Top risks will be identified in the revised Strategic Plan for the FHRHA. Examples of some risks and associated responses have been summarized in the table that follows:

RISK DOMAINS:					
Operational	**Financial**	**Human Capital**	**Customer & Community Relations**	**Legal and Regulatory**	**Technology**
RISK MANAGEMENT (list not exhaustive, but indicative):					
Occurrence Reports Review of serious events Emergency Measures drills Infection Control Claims Management Chart reviews Program Reviews Management of workers' compensation claims Presentations (fiduciary responsibilities) Restraint policy and compliance Compliance with issue alerts Ensuring effective credentialing Monitoring and implementing compliance with standards on patient/ client/ resident safety	Policy Limits e.g. Purchasing, investments Financial audit Financial monitoring and reporting Contract reviews with third parties Review and reporting of dashboard indicators Maintaining capital reserves Having indemnity clauses in contracts	OH&S actions Employee Incident Reports Environmental safety Transfers, Lifts, Repositioning Training Strike contingency Harassment policy, process Conflict of Interest policy Human resource monitoring and reporting Credentialing Orientation programs for staff, volunteers, physicians, students Staff training Recruitment & retention	Complaints monitoring and investigation Single point of entry practice Advanced care directive policy and implementation Compliance with informed consent Review of research proposals Issues management Communication strategy for community interest items	Legislative compliance Ensuring certification and Licensing compliance Accreditation improvement plan Reporting OH&S requirements and reporting investigating results Reviewing and Reporting of Critical Incidents HIPA policies and compliance oversight Morbidity & mortality reviews	Compliance with product/ equipment alerts IT security monitoring IT data security policies and reviews Preventative Maintenance Planning for equipment replacement Capital planning Facility planning

While not a complete list, opportunities and threats and the associated risks encountered by the Regional Health Authority can be summarized as follows:

- **Demographic changes** – the population of the region is predicted to continue to decline. If past trends continue, out-migration from rural areas will be the most pronounced. The senior population will decline – only to peak again in 15 years with an aging baby boomer population. Retention of the young workforce – representing a source for future health workers and the future tax paying generation - will be a continued challenge. Services cannot and should not be sustained at their current levels. Services must evolve to meet the ever changing population needs.
- **Changing health needs and trends** – chronic illness care continues to emerge as the prevalent need in the population. The upstream challenge of obesity and a lack of physical activity will increase this strain on the health system. At the other end of the spectrum, the number of outbreaks and the risk of pandemic will also rise.
- Acute care system that is poorly designed for **chronic and complex care** needs that are emerging. Primary health care reform is slow to progress – creating the potential for a new crisis. Acute care services will continue to be burdened with waitlists created through the inappropriate (and lack of) care for those suffering from chronic illness.
- **Access** issues – patient continue to deal with access issues related to a lack of transportation, unnecessary waits for health services, a lack of mobile services, and a lack of access to tele-health and tele-home care alternatives.
- The multiple acute care systems – the **patient journey** is most likely to begin in a setting outside of the Health Region service – perhaps within a physician's office. The system of referral and information flow is poorly designed and requires modernization and standardization. In addition, patient flow between facilities, services and regions needs improvement – with every handoff creating risk of error and miscommunication. The lack of **information systems** to assist in what is currently a paper system need further focus. The false division between these private providers and multiple agencies needs to be resolved.
- Staff **recruitment and retention** will be an increasing challenge as the health region responds to the demographic reality of the population.
- **Patient safety** and system redesign needs to take place in order to match the safety standard of other industries – such as the airline industry.
- **Capital** infrastructure – rigid building designs will need to evolve with the change in needs and evolution of services.

Contracted Health Care Organizations

The Five Hills Regional Health Authority has contracted the following health care organizations and private providers to deliver health services:

Angus Campbell Centre

- Operates a 20 bed residential (social) detox centre for drugs and alcohol.

Thunder Creek Rehabilitation Association

- Provides residential services and programs for adults with severe and persistent mental illness.

Canadian Mental Health Association

- Provides community education and awareness of mental illness.

Moose Jaw and District EMS

- Provides ground ambulance services for Moose Jaw and area and 911 dispatch services for the entire region.

Wald Ambulance

- Provides ground ambulance services for Assiniboia and area.

Providence Place

- Operates a160 bed long term care facility, 14 bed Geriatric Assessment and Rehabilitation Unit, and adult day program located in Moose Jaw.

St. Joseph's Hospital/ Foyer d'Youville

- Operates a 50 bed long term care and 9 bed acute care facility in Gravelbourg.

Extendicare

- Operates a 127 bed long term care facility in Moose Jaw.

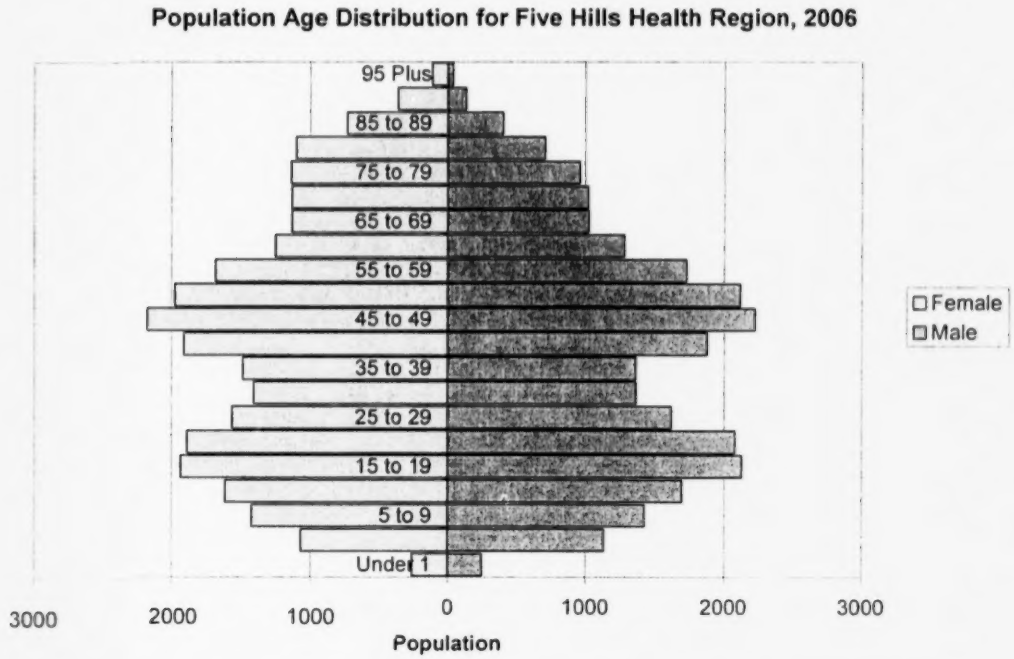
Revision date: October 19, 2006

Our Region

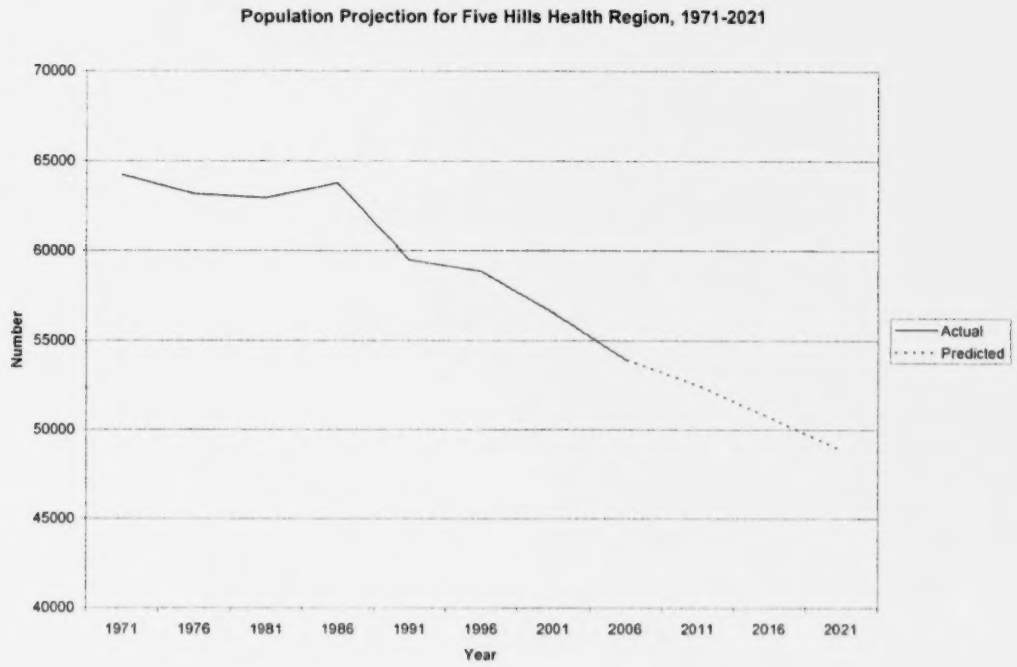
The Five Hills Health Region has prepared a comprehensive health status report for the population served. The report summarises information from a number of internal and external sources and includes needs assessment data compiled by the former Moose Jaw - Thunder Creek Health District and South Country Health Districts. The approach to needs assessment was historically highly coordinated between the former districts, and involved an intersectoral approach to needs identification and strategic response. Age cohorts were used in focussing needs assessment work (prenatal to age 4, child & youth 5-19, adults 20-64, seniors 65+). The following is a summary of some of the data that has been compiled. Source documents provide a more comprehensive overview.

FHHR indicators were derived from the Canadian Institute of Health Information's Structural Framework of Health Indicators from four broad categories of Health Status, Non-Medical determinants of Health, Health System Performance and Community and Health System Characteristics. The source of the data for these indicators is provided by Saskatchewan Health, Regional Hospitals, Canadian Community Health Survey, Breastfeeding Survey, Child & Youth Needs Assessment, HSURC (now HQC), Health Canada and Stats Canada.

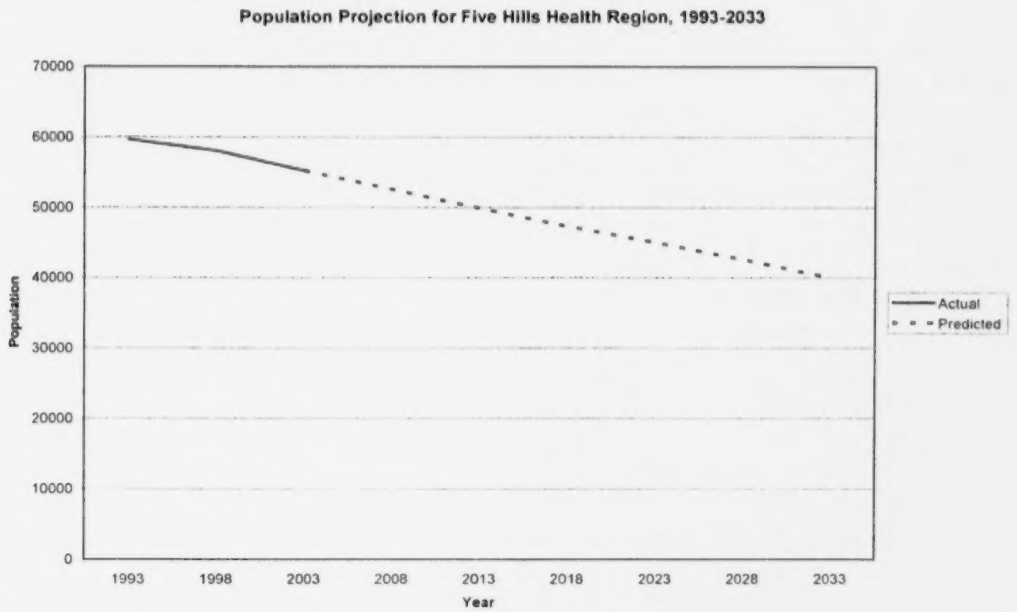
Five Hills Health Region Demographics



The City of Moose Jaw accounts for the largest portion (63%) of the Region population. The population of the FHHR as of 2006 was 53,921. About 22% of the FHHR residents live in towns and villages, 63% live in Moose Jaw and 15% live in RM's.



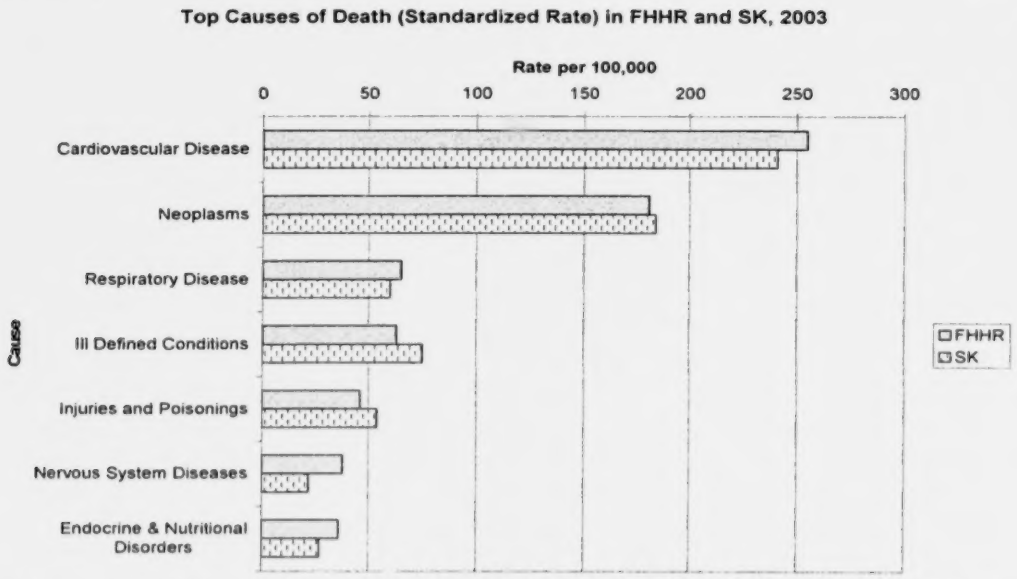
Source: Sask Health & Stats Canada



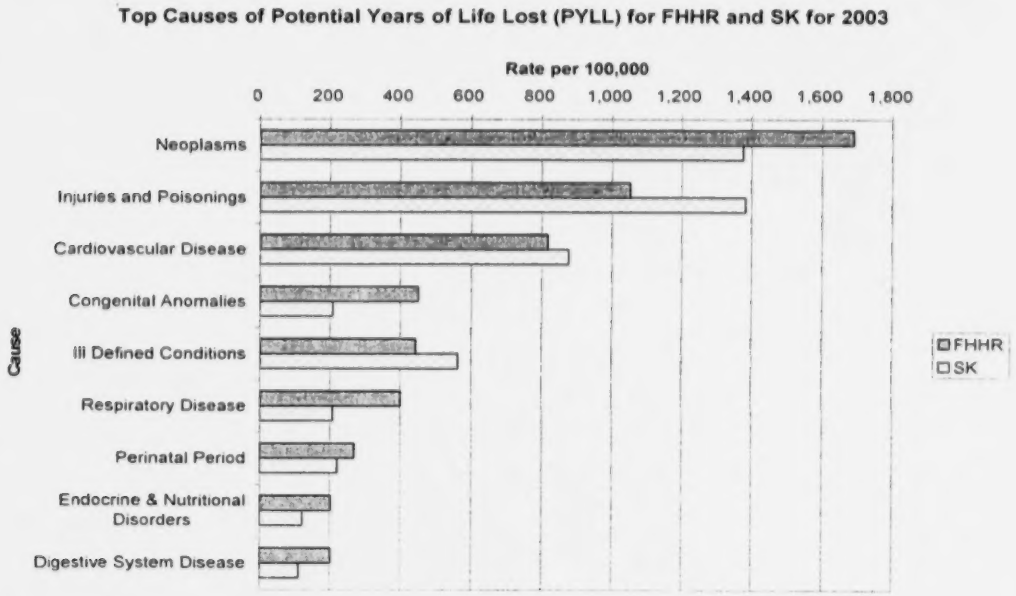
Source: HSURC population projection spreadsheet template

The projected population for the Five Hills Health Region is shown to be steadily decreasing over the next twenty years (1971-2021) and the next thirty years (1993-2033). **Reassessments need to be done every five years**.

Health Status
Mortality



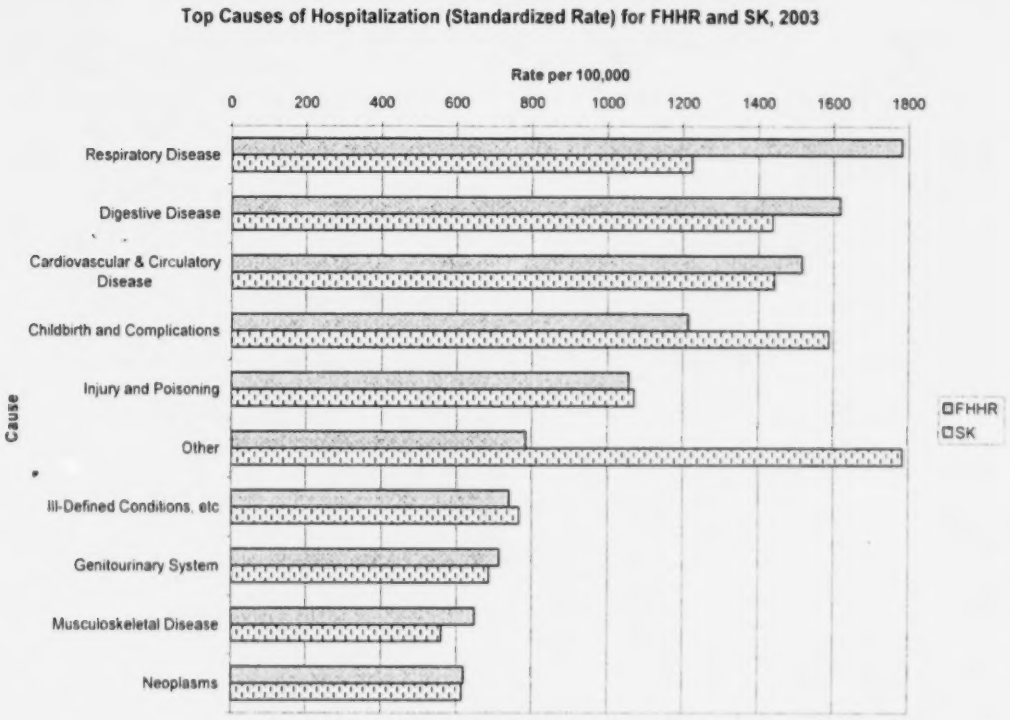
Cardiovascular disease, neoplasms and respiratory disease appear as the top three causes of death in FHHR.



PYLL measures premature deaths. Although death rates from various diseases are important, the measure of premature and preventable death is of more interest since programs and activities may reduce these premature deaths along with associated morbidity.

Morbidity

The single highest cause of hospitalization is respiratory disease followed by digestive disease, cardiovascular disease, childbirth & complications and injury. Co-morbidities and health behaviours such as diabetes (an endocrine disease), smoking, sedentary lifestyles, obesity, hypertension, and hypercholesterolemia, impact significantly on cardiovascular disease.



Diabetes: Hospitalizations due to diabetes are distributed through the lifespan, from youth to old age. Complications of diabetes such as cardiovascular disease are listed as separate hospitalization diagnoses. In Saskatchewan, the overall prevalence rate of diabetes was 3.7 % (1996). In 2001, the SK prevalence had risen to 4.1% and in 2004 the prevalence had risen again, to 6.1% but decreased to 5.8% in 2005. The likelihood of having diabetes is proportional to age.

Age Specific Diabetes Prevalence (%) for Saskatchewan, 2004

20-29	30-39	40-49	50-59	60-69	70+
0.5	1.8	3.4	7.5	12.9	15.4

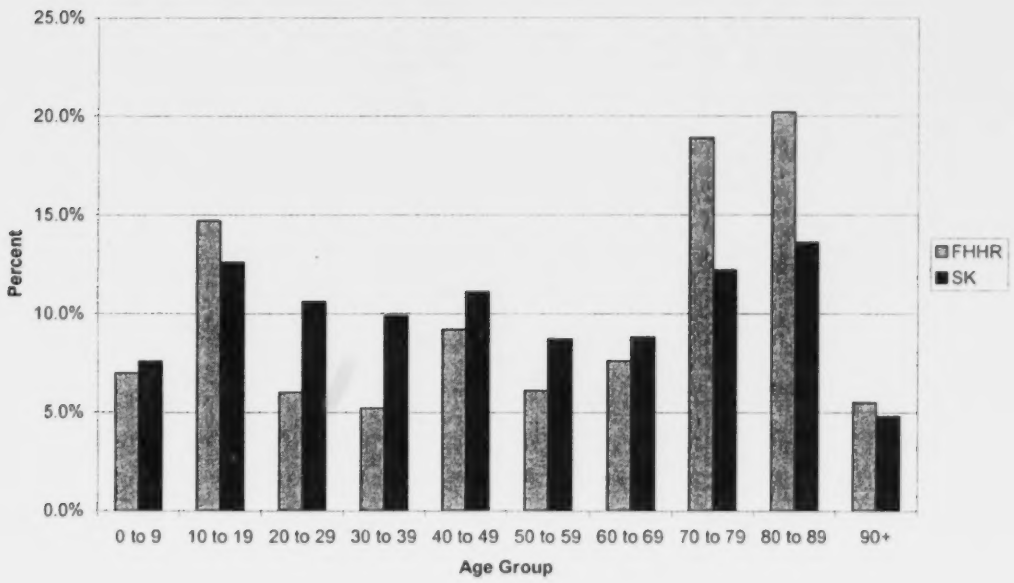
Regional age-sex adjusted prevalence rates per 1000: 2002/03 - 47.9, 2003/04 – 50.9 and 2004/05 – 53.8.

Approximately 90% of diabetic people have Type II Diabetes which is associated with age, obesity, and physical inactivity (Diabetes 2000).

Asthma: Asthma hospitalizations are most common in children and young adults. Hospitalizations due to asthma in FHHR, 2003 were highest in the age groupings under 1 (14%), 1 to 4 (42%) and 5 to 9 (16%). In this same period, all age group asthma hospitalizations accounted for 1.2% of hospitalizations in the region. Saskatchewan Health estimates exposure to environmental tobacco smoke raises a child's risk of asthma by 43% and of bronchitis by 46% (2001).

Injury: In, 2003, the highest number of hospitalizations is for FHHR seniors aged 70 to 79 (18.9%) and 80 to 89 (20.2%). Five Hills Health Region residents may be hospitalized in other regions as well. According to the Hospitalizations for Child Injuries in FHHR, for children under 20 years of age, for the period 2003, the following types of accidents accounted for hospitalizations: falls (28.5%), motor vehicle or traffic (17.9%), surgical/medical complications (10.1%) and other (22.3%).

Injury Hospitalizations by Age Group out of All Injury Hospitalizations for FHHR and SK, 2003



Life Expectancy: In **2001**, life expectancy for both sexes at birth was almost 79 years (75.7 males; 81.6 females) and almost 19 (further) years (16.2 males; 20.6 females) at age 65 for FHHR. This was similar to the provincial figures.

Disability-free Life Expectancy: Life expectancy is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), on the basis of the mortality statistics for a given observation period. Disability-free life expectancy is a more comprehensive indicator than that of life expectancy because it introduces the concept of quality of life. It is used to distinguish between years of life free of any activity limitation and years experienced with at least one activity limitation.

Disability-free life expectancy at birth: Canadians born in 1996 were expected to live free of any disability for 68.6 years of their life. For the same year, SK was at 68.3 years (66.6 males; 70.0 females), and FHHR was at 68.2 years (66.5 males; 69.8 females). Most major urban centres have high disability-free life expectancy at birth as compared to below-average disability-free life expectancy at birth in most of the Far North and rural Atlantic Canada.

Disability-free life expectancy at age 65: In 1996, Canadians aged 65 years were expected to have another 11.7 disability-free years left to live. For the same year, SK was at 12 years (11.2 males; 12.7 females) and FHHR was 12 years (11.2 males; 12.7 females). Most high-density metropolitan areas have high disability-free life expectancy at age 65 as compared to below-average disability-free life expectancy at age 65 in most of Northern Canada. Disability-free life expectancy was not significantly different from the national average in the other health regions of Far Northwestern Canada, peer group F, which is comprised of health regions in Northern Canada, mainly in the Prairies, British Columbia and the territories.

Health Adjusted Life Expectancy (HALE): is an indicator of overall population health. It combines measures of both age- and sex-specific health status, and age- and sex-specific mortality into a single statistic. HALE represents the number of expected years of life equivalent to years lived in full health starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), based on the average experience in a population. In this sense, HALE is not only a measure of quantity of life but also a measure of quality of life. SK & FHHR stats are pending.

Infant Mortality, Teens and Birth Weights:

From **1998-2004**, infant mortality in FHHR has been lower than the province most years. Range in FHHR is 2.7– 9.1 per 1000, averaging at 6.5. The SK IMR ranges from 5.6 – 8.9, with an average of 6.2.

Most babies are born to mothers between 20 and 34 years of age in FHHR. Teen pregnancies in FHHR peaked in 1998 at 12.8 % of all births. The rate is declining and 2003 birth data, the teen birth rate was 7.5% of all births [Saskatchewan rate is 9.9%]. For FHHR, in 2004 & 2005, teen birth rate continues to decline (7.45 and 5.9% respectively).

High birth weights in the FHHR for 1998 to 2004 was a rate of 14.3 % (Saskatchewan 15.6%).

Low Birth-Weights (LBW) expressed as a % of all births: Between the years **1998 and 2004**, FHHR range of % LBW for FHHR: 4.4 – 7.0% (av. = 5.0); for SK: 5.1 – 5.5 % (av. = 5.4). Birth weights are impacted upon by smoking in pregnancy, race, parity, maternal size, socio-economic status, gender of baby, and gestational and maternal age.

Breastfeeding: From then 0-5 Needs Assessment, exclusive breastfeeding to 4 months was significantly below the accepted national rate. This was due in part to the inappropriate use of supplementation of formula or glucose-water and not strictly adhering to the breastfeeding definition. Initiation of "some" breastfeeding was 87%. Only 37% still did "some" breastfeeding at 6 months. From the 2001/02 Breastfeeding Survey, initiation of "some" breastfeeding was 92% and 37% still did "some" breastfeeding at 6 months. The Canadian

Paediatric Society, Dieticians of Canada, and Health Canada recommend exclusive breastfeeding for at least the first 4 months of life and continuing with other foods to 2 years and beyond.

The second survey (2002/03) showed, initiation of "some" breastfeeding was 92%. Only 37.3% still did "some" breastfeeding at 6 months.

From the CCHS 2003 & 2005, 16% and 32% (respectively) of FHHR mothers exclusively breastfed for at least 6 months (20% and 23% respectively for SK).

Self-Rated Health Status: In FHHR, in 2001, 59% of people rated their health as very good to excellent as compared to 57% in the province. (CCHS, 2001) For 2003, FHHR, 56% of people rated their health as very good to excellent as compared to 60% in the province. (CCHS, 2003) And in **2005**, 55.7% of FHHR residents rated their health as very good to excellent as compared to 52% in the province. (CCHS, 2005)

Non-Medical Determinants of Health

Income and Social Status: Statistics Canada has unveiled (27th May 30, 2003) a new poverty measure, namely the Market Basket Measure. Looks at poverty rates by geography, taking into account rents and cost of essential food items, amongst others. Saskatchewan is about in the middle of the field at 13.9% of inhabitants living in "market basket" poverty (range: NFLD @ 23.4%, to ONT @ 11%). *(Note: Regional data not available at this time).* Low income cut-offs are still used as well. The low income cut-off is under $30,000 before tax annual income.

In FHHR in 1999, 17% of households made less than $20K, 53% made between $20K and $60K and 30% made over $60K. Twelve percent of the FHHR families are single parent and have an average total income of $26,106. The average married total income is $51,790. For FHHR in 2001, 11.2% of families were considered to have low income (11.8% for SK). In 2001 in FHHR, 18.6% of children 17 and younger belonged to low income families (19.0% for SK).

In FHHR in 2006, 15% of households made less than $20K, 38% made between $20K and $60K and 22% made over $60K (Adult & Seniors Needs Assessment, 2006).

Households on government assistance: 2004/2005 as of April 2005.
1227 people/families are on some kind of government assistance program in Moose Jaw and surrounding areas. 5.6% are on transitional employment allowance (69/1227 = 5.6%) and 94.4% are on full social assistance (1158/1227 = 94.4%).

Of the 1158, 67.8% are single adults (785/1158 = 67.8%), 4.9% are childless couples (57/1158 = 4.9%), 22.8% are single parent families (264/1158 = 22.8%), and 4.5% are two parent families (52/1158 = 4.5%).

From the 2002 Child and Youth Needs Assessment, 6.5% of 10 to 19 were in families that used food programs to get enough food.

Education: From the CCHS 2003, 33.8% of adults had less than a secondary education, 23.4% had a secondary education, 6.6% had a trade, diploma or some college/university and 34.5% had a post secondary degree. From the CCHS 2005, 30.0% of adults had less than a secondary education, 19.9% had a secondary education, 7.0% had a trade, diploma or some college/university and 41.1% had a post secondary degree.

In a recent survey (2003) of select areas of the region, 20% of adults had less than a secondary education, 27% had a secondary education, 52% had post secondary education. From the 2006 Needs Assessment, 24.8% of adults had less than a secondary education, 11.3% had a secondary education, 44% had a trade, diploma or some college/university and 20% had a post secondary degree

Physical Activity: For FHHR in 2001, 40.9% of residents are moderately active to active (SK – 44.1%) and 51.2% of residents are inactive (SK – 48.9%). 2003 Rates of physical Activity in FHHR and SK. There is a discrepancy in data due to the database sourced.

Derived from CCHS 2003	moderately active/active FHHR	inactive FHHR	moderately active/active SK	inactive SK
Stats Can data (entire file)	49.9%	48.3%	49.6%	47.8%
SK health data (share file)	50.6%	47.6%	49.8%	47.8%

From CCHS 2005, 46.4% of residents are moderately active to active (SK – 48.6%) and 51.2% of residents are inactive (SK – 49.5%). In May 0f 2007, FHHR is conducting an Adult and Senior Anthropometric Assessment of a resident survey group, as well as physical activity levels, and pain-scores.

Body Mass Index: Body mass index (BMI)-Canadian standard, which relates weight to height, is a common method of determining if an individual's weight is in a healthy range based on their height. BMI is calculated as follows: weight in kilograms divided by height in metres squared. The index is: under 18.5 (underweight), 18.5-24.9 (acceptable weight), 25-29.9 (some excess weight) and greater than 30.0(overweight). The index is calculated for those aged 20 to 64 excluding pregnant women and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).

Over-consumption of food with poor nutrient quality (high fat, high sugar, high calorie, low nutrients) contributes to obesity, Saskatchewan's silent epidemic. This results in premature death and morbidity from cardiovascular disease and Type II Diabetes, amongst others. High rates of smoking in FHHR further exacerbate premature deaths due to cardiovascular disease.

2003 Rates of overweightness and obesity in FHHR and SK. There is a discrepancy in data due to the database used. Resolution has been made by SK (May 2005).

Derived from CCHS 2003	Overweight FHHR	Obese FHHR	Overweight SK	Obese SK
Stats Can data (entire file)	37.7%	22.6%	35.5%	19.7%
SK health data (share file)	41.8%	25.9%	35.8%	20.5%

From CCHS 2005, 32.7% of residents are overweight (SK – 32.5%) and 18.3% of residents are obese (SK – 20.0%).

In May 0f 2007, FHHR is conducting an Adult and Senior Anthropometric Assessment of a resident survey group, as well as physical activity levels, and pain-scores. Results will be available in June 2007 (survey) and September 2007 (anthropometric assessments).

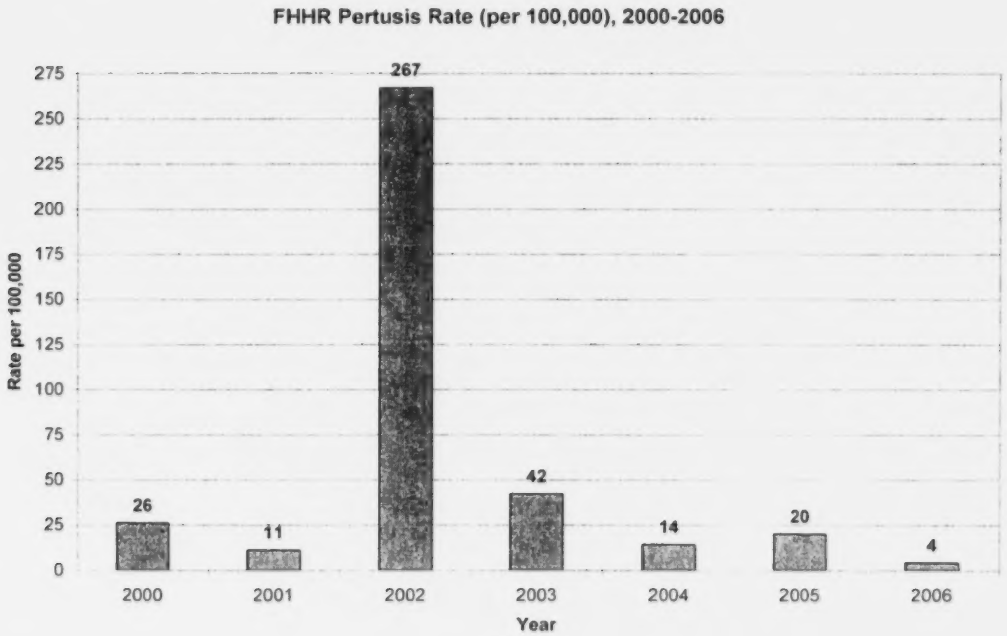
Smoking: In FHHR in 2003, 24.1% (22.9% males; 25.3% females) of adults between the ages of 12 to 65 smoked compared to the 24.0% (24.6% males; 23.9% females) of adults of the same age group in the province. There is a clear social gradient between smoking and income level. For example, those earning $12K to $40K had a smoking rate of 40% whereas those earning over $70K had a rate of 19% (2001).

Youth: 18% of 15-19 year olds in Canada in 2003 smoked (Health Canada). 10% of 12-17 year olds in Canada in 2003 smoked (CCHS, 2003). In FHHR in 2002, 20.2% of youth smoke cigarettes daily (2002 Child & Youth Needs Assessment).

In FHHR in **2005**, 21.1% (24.6% males; 17.6% females) of adults between the ages of 12 to 65 smoked compared to the 24.2% (25.6% males; 22.8% females) of adults of the same age group in the province.

Health System Performance

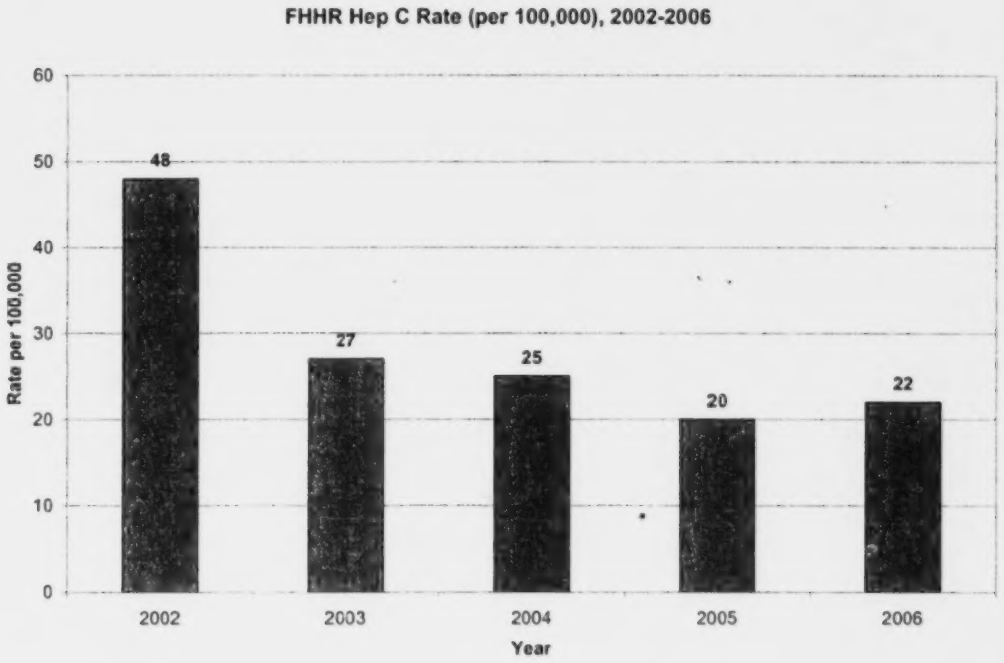
Pertussis:



The 5 to 12 age group is predominantly affected. The significance of these diseases is that considerable time and staff resources are needed in following up cases and contacts. Also potential for severe disease in the very young or immunocompromised. Pertussis in adults

and adolescents is thought to be under-diagnosed. [A relatively new vaccine against pertussis (Adacel) is available for people of age 12-54 years. This is now part of the provincially funded childhood immunization program].

Hepatitis C:



In the Province, between 1998 and 2000, 70% of the new cases had IV drug use (IDU) as a risk factor, whereas in FHHR, at least 37% of those who tested positive for Hepatitis C were intravenous drug users. Risk factors could not be determined for some patients.

A harm reduction program (including a needle exchange program) for injection drug users was established by Public Health in 2002. It includes appropriate immunizations, serological testing, counselling and referrals to addictions, social services, physicians, etc.

HIV: In FHHR for the years 1998 through 2006 there were a total of 9 officially reported cases, with an average of 1 case per year (2006 stats under review).

Immunization Rates:

As per Canadian National standard, the coverage rate is the specific rate of immunization coverage, by a child's second birthday. This is an important milestone, as a child should have received the primary immunization series by this time.

The following Table represents the percentage of eligible population receiving immunization at second birthday, for FHHR and the Province - this for children who turned 2 years old between July 1st 2004, and June 30th, 2006.

Immunization Rates: **for children who turned 2 years old between July 1st 2004, and June 30th, 2005[1] ; and July 1st 2005, and June 30th, 2006[2]**

Regional Health Authority	Population who attained age 2 in given year (covered pop)	Population who attained age 2 in given year and are registered in SIMS**	Rate by Antigen (%)							
			Diphtheria	Haemophilus influenzae type b	Measles	Mumps	Pertussis	Polio	Rubella	Tetanus
Five Hills[1]	**566**	**548**	**86.5**	**86.1**	**83.9**	**83.6**	**86.5**	**86.3**	**83.9**	**86.5**
Saskatchewan[1]	11,988	10,854	72.9	72.2	71.2	71.1	72.9	72.9	71.2	72.9
Five Hills[2]	**543**	**432**	**82.1**	**81.7**	**80.4**	**80.4**	**82.1**	**82.3**	**80.4**	**82.1**
Saskatchewan[2]	**12179**	**8145**	**73.5**	**72.7**	**72.7**	**72.5**	**73.5**	**73.5**	**72.4**	**73.5**

The 2006 data, reflects a smaller SIMS population, in turn reflecting a cleaning of data, and this is the data to be utilized, until further notice.

Influenza Immunization rates for seniors (65 years of age and above):

This is a cost-effective population health measure, reducing both morbidity and mortality due to respiratory causes, in this vulnerable age-group. The information in the table below indicates that FHHR has steadily increased its percentage of those covered by the 'flu shot, over the last three reporting periods:

RHA, Year	% Adults 65+ Immunized
FHHR 2002/2003	65%
FHHR 2003/2004	66%
FHHR 2004/2005	68%
FHHR 2005/2006	67%
SK 2002/2003	62%
SK 2003/2004	66%
SK 2004/2005	68%
SK 2005/2006	66%

Emerging Issues

1. Viral and Bacterial Diseases:

1.1. Planning for Emerging Major Communicable Disease events:

Planning for these eventualities is important. It has led to the formation of strategic groupings such as the South Saskatchewan Pandemic Planning Group, as well as working groups within the FHHR itself.

Major (communicable) diseases may include influenza (both pandemic and avian high-pathogenic types). It is noted at this time, that Avian influenza H5N1 does not have the capacity for human to human spread, but this property could develop at any time.

Pandemic planning continue with the drafting of operational plans. Planning is being conducted around moderate severity impact figures, for FHHR.

This region is participating in the construction of a package of Pandemic-related information for physician's offices.

1.2. Arbovirusses such as West Nile Virus are now established in Saskatchewan, and the FHHR. This is reflected in more circumspect and focused bird and mosquito surveillance techniques.

This disease is dependent on the mosquito vector, and mosquito proliferation in turn is heat-dependent. Global warming will influence these and other disease vectors, giving rise to the term transmerging diseases, i.e. the emergence or re-emergence of infectious diseases, new and old, against the background of a transforming weather and economic environment. A good example is dengue fever, rapidly spreading across South America and the Carribean.

Surveillance will also detect new mosquito vectors in our region, allowing us to on the lookout for accompanying diseases such as Saint Louis Encephalitis, should it move north.

1.3. Antibiotic resistant organisms (ARO's) are on the rise, requiring continually changing approaches to stay ahead of organisms including MRSA and MDR-Tuberculosis, for example. Some staphylococci are becoming resistant even to the fluoroquinolone group of antibiotics. To interrupt transmission of these and evolving resistant organisms, we need to:

- know about the latest mechanisms of how this resistance is conferred, i.e. by plasmids and integrons
- realize that the old standbys of hand hygiene and barrier isolation precautions, remain critically important

2. Special Interest Groups:

Immigrants, refugees and otherwise, need a lot of assistance in order to settle successfully in our country. Access to health services is included in this process, and we need to continually strive to facilitate this process. This includes the necessary supports to facilitate the transition to the health services of a developed country such as ours. Language and cultural barriers present real obstacles to realizing this endeavour.

Ongoing close cooperation with Multicultural Centres is essential. Planning has enabled Public Health Nurses to begin screening Multicultural Centre immigrants as of May 2007, from a primary health care (PHC) perspective, and to liase with specific physicians, to expedite appropriate PHC modalities.

3. The importance of Health Status Assessments using amongst others surveys, personal interviews and measurements:

As regards health behaviours, most of our information is based on self-reporting via agencies such as CIHI. In May 0f 2007, FHHR is conducting an Adult and Senior Anthropometric Assessment of a resident survey group, as well as physical activity levels, and pain-scores. Results will be available in June 2007 (survey) and September 2007 (anthropometric assessments). It is hoped that this information will provide us valuable insights into how best to combat rising levels of physical inactivity, and overnutrition. Diabetes and cardiovascular disease amongst others, are known results hereof.

4. Teen Sexual Health Promotion:

In addressing this issue, a teen Sexual Health focus group was conducted in FHHR. The purpose of this project was to identify sexual health issues and promote awareness of sexual health services for adolescents and young adults in FHHR.

The next step is, via the Public Health Nurses, to present the findings of the report to the grade 8 students. Our goal is to help improve their transition to high school and to make them aware of existing community resources that they can access, for sexual health needs.

2006-07 Results at a Glance

This section briefly highlights the significant events and accomplishments throughout the fiscal year including performance, strategic, operational, and financial achievements that pertain to goals and the financial summary.

During 2006-07 the Five Hills Health Region achieved many objectives and reached many successes that are in line with the strategic goals. There were also challenges in obtaining some goals and desired results. Below is a summary of the important highlights.

GOAL 1 IMPROVED ACCESS TO QUALITY HEALTH SERVICES

- Access – **wait times** are regularly monitored and managed in the area of therapeutic, surgical and diagnostic services. The prime objective continues to be to reduce or remove unnecessary waits. Expansion of telehealth services continues to be explored.
- Primary Health Care – In addition to nurse practitioner and team based **primary health care** in Central Butte, this initiative is being expanded to include Assiniboia (including Rockglen, Willow Bunch, Mossbank), and Kincaid. Craik and Assiniboia physician practices have been involved in the Health Quality Council chronic disease management collaboratives.
- Secondary Services – The **specialties** of obstetrics and pediatrics have been expanded with the introduction of second full time specialist to provide continuous coverage. On-site ER physicians were introduced at MJUH. CT services have been enhanced. Expanded **hemodialysis** services are planned for summer, 2007.

GOAL 2 EFFECTIVE HEALTH PROMOTION AND DISEASE PREVENTION

- The establishment of a **community advisory network** in rural areas of the region – with regularly scheduled community-wide meetings held in Craik and area, Central Butte and area, Gravelbourg and area, Assiniboia and area, Rockglen and area, Lafleche and area, and Avonlea and area. Communities are developing their own priorities and action plans – based upon the health needs of their local population. Partnerships with other service and government sectors are being explored.
- Population Health – a **population health promotion plan** has been developed and implemented.

GOAL 3 RETAIN, RECRUIT AND TRAIN HEALTH PROVIDERS

- Safety – **Staff safety** initiatives have been introduced.
- Recruiting/ Retaining - Staff **satisfaction** has been measured – and various strategies have been implemented to improve the quality of the workplace experience.

GOAL 4 A SUSTAINABLE, EFFICIENT, ACCOUNTABLE, QUALITY HEALTH SYSTEM.

- Client Centered Services – the region has initiated a **customer services** initiative through staff training and orientation sessions.
- Quality – The region has introduced a new quality initiative named **Pursuing Excellence** – that examines services from the patient, resident, clients perspective and seeks to eliminate wasted steps and defects in the care and service delivery process.
- **Patient safety** initiative such as a new sepsis protocol, stroke protocol, and trauma protocol have been implemented. The RHA has participated in the Safer Health Care Now initiative through these rapid response teams and the Health Quality Council sponsored ICU Collaborative.
- Capital – plans for a **new wing** at Moose Jaw Union Hospital have been proposed.

FINANCIAL SUMMARY

- There was a surplus of 1,715,029

2006-07 Performance Results

GOAL 1
IMPROVED ACCESS TO QUALITY HEALTH SERVICES

Further discussion on the rational and explanation of the following Mandatory Dashboard indicators is provided in Appendix A:

Indicator	RHA Value	Provincial Value	Range	Target
Number of patients as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*	103.7%	98.0%	93.5% – 111.0%	100%
Number of exams as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*	99.6%	107.3%	73.5% – 125.6%	100%

Saskatchewan Health has negotiated annual target volumes of patients with each health region.

Patients can have more than one exam in a single visit. For this indicator, the number of patients refers to the number of visits, not discrete patients. So, if an individual patient has more than one visit over the course of a specified time period (e.g. quarter, year), they will be counted for each visit.

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of Priority Level I, II, III and IV surgical cases completed within target time frames[13] *2006/2007*	Priority Level I within 3 weeks	78.8%	57.3%	43.7% – 97.4%	95%
	Priority Level II within 6 weeks	61.9%	43.8%	0.0% – 96.6%	90%
	Priority Level III within 3 months	86.6%	63.9%	43.3% – 100.0%	90%
	Priority Level IV within 12 months	97.4%	88.0%	79.3% – 100.0%	90%
Cumulative number of surgical cases performed as a percentage of target and variance from target[13] *2006/2007*	Percentage of target	98.9%	98.3%	85.2% – 122.4%	100%
	Variance from target	-42	*not applicable*	*not applicable*	*not applicable*

Indicator	RHA Value	Provincial Value	Range	Target
Average wait time for admission to alcohol and drug inpatient services[19] *February and March 2007*	*not applicable*	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug detoxification services[20] *February and March 2007*	5.2 days	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug stabilization services[21] *February and March 2007*	*not applicable*	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug long term residential treatment services[22] *[data not available]*	———	———	———	———

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of RHA population with geographic proximity to primary health care teams *March 2007*		4.99%	19.98%	0.00% – 100.00%	25% of SK residents by 2006, 100% by 2011
Number of discrete clients receiving primary health care services in the RHA *2006/2007*	Q1	1054	*not applicable*	*not applicable*	*not applicable*
	Q2	1087			
	Q3	1083			
	Q4	966			
Total number of new primary health care teams developed in the current year *2006/2007*		0	*not applicable*	*not applicable*	*not applicable*

Factors that affect the percentage of RHA population with geographic proximity to primary health care teams include: available budget at the provincial level, the signing of the Memorandum of Understanding between the Saskatchewan Medical Association (SMA) and the Regional Health Authorities, and availability of health care providers.

Discrete patients are the patients that sought the services of the primary heath care team within the Regional Health Authority (RHA). Patients are only counted once by the team and the patient residence is not necessarily within the RHA.

Secondary Services – The **specialties** of obstetrics and pediatrics have been expanded with the introduction of second full time specialist to provide continuous coverage. On-site ER physicians were introduced at MJUH. CT services have been enhanced. Expanded **hemodialysis** services are planned for summer, 2007.

Indicator		RHA Value	Provincial Value	Range	Target
Number of Healthline calls for the RHA *2006/2007*	Q1	1082	*not applicable*	*not applicable*	*not applicable*
	Q2	846			
	Q3	849			
	Q4	1213			
	Year as a whole	3990			

All residents of the province have access to the toll-free number: 1-877-800-0002. TTY access is available for the hearing impaired. Translation services are also available for those requiring communication in a language other than English. Specially-trained social workers and registered psychiatric nurses (RPNs) are available to handle crisis calls and provide referrals.

GOAL 2
EFFECTIVE HEALTH PROMOTION AND DISEASE PREVENTION

Further discussion on the rational and explanation of the following Mandatory Dashboard indicators is provided in Appendix A:

Indicator	RHA Value	Provincial Value	Range	Target
Percentage of facilities in compliance with *The Tobacco Control Act* in the category that includes: billiard halls / bingo establishments / bowling centres / casinos / restaurants / taverns *[data is currently not available due to system implementation issues]*	——	——	——	90% compliance

Inspections for *The Tobacco Control Act* are, for the most part, done during other routine inspections by public health inspectors for food safety. Public Health Inspectors (PHIs) also respond to complaints about violations of *The Tobacco Control Act*. The number of inspections will depend on the number of routine inspections and the number of complaints received by PHIs.

The establishment of a **community advisory network** in rural areas of the region – with regularly scheduled community-wide meetings held in Craik and area, Central Butte and area, Gravelbourg and area, Assiniboia and area, Rockglen and area, Lafleche and area, and Avonlea and area. Communities are developing their own priorities and action plans – based upon the health needs of their local population. Partnerships with other service and government sectors are being explored.

Population Health: a **population health promotion plan** has been developed and implemented.

GOAL 3
RETAIN, RECRUIT AND TRAIN HEALTH PROVIDERS

Further discussion on the rational and explanation of the following Mandatory Dashboard indicators is provided in Appendix A:

Indicator		RHA Value	Provincial Value	Range	Target
Number of wage-driven premium hours (overtime and other premiums) per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	19.61	36.85	16.36 – 91.10	*to be determined*[3]
	HSAS	8.89	25.44	0.25 – 117.97	*to be determined*[3]
	OOS/OTHER[1]	1.37	3.46	0.00 – 16.92	*to be determined*[3]
	SUN	27.14	81.54	27.14 – 368.66	*to be determined*[3]
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*to be determined*[3]
	Organization as a whole	18.96	42.47	17.19 – 131.56	*to be determined*[3]
Number of sick leave hours per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	89.43	89.78	71.62 – 107.61	*to be determined*[3]
	HSAS	51.04	65.62	44.65 – 92.53	*to be determined*[3]
	OOS/OTHER[1]	47.00	47.34	27.68 – 61.46	*to be determined*[3]
	SUN	81.10	89.34	63.83 – 96.84	*to be determined*[3]
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*to be determined*[3]
	Organization as a whole	81.77	84.12	64.15 – 93.63	*to be determined*[3]
Number of lost-time WCB claims per 100 full time equivalents (FTEs) *2006/2007*		5.90	7.67	0.53 – 10.00	*to be determined*[3]
Number of lost-time WCB days per 100 full time equivalents (FTEs) *2006/2007*		630.54	468.45	38.43 – 766.40	*to be determined*[3]

Sick Leave

Work absence correlates closely with turnover, and therefore becomes an early warning of retention issues. It can also affect the morale of the employees who come to work every day (Fitz-enz and Davison 1995). Addressing its root causes could contribute significantly to employee quality of life and the health care system's overall efficiency and cost-effectiveness.

Wage-Driven Premium Hours (Overtime and other premiums)

Overtime hours have become an increasing concern for Regional Health Authorities (RHAs), the Saskatchewan Cancer Agency (SCA) and Saskatchewan Health over the past few years. Historically the department has not funded overtime hours, which results in these funds coming directly from organizations' operating budgets. Overtime hours tend to increase during periods of peak utilization and can be closely correlated with sick time being recorded by organizations – as sick time goes up and the available pool of employees diminishes, managers are forced to bring staff in / keep staff on in overtime situations. Not only is this financially problematic, the pressure on employees to maintain a high standard of care and service is taxed by continual overtime hours.

Overtime hours can also be associated with understaffed areas or professions / positions that have typically been hard to recruit or retain employees.

Lost-time WCB Claims/Days

Workplace injuries in the health sector are influenced by a number of factors including the availability and uptake of occupational health and safety training, the existence of unrecognized risk, general employee knowledge and expectations regarding health and safety, and a lack of corporate commitment to have a "culture of safety" in the workplace. Research shows that when workplace safety is articulated and reinforced as one of the core operational values, injury rates and consequently costs to the system are lower.

The Saskatchewan Provincial Auditor recommends that regions commit at the board level to workplace safety by setting specific short-term targets, allocating resources, receiving regular reports and holding senior managers accountable for reducing injuries in the workplace.

Safety: **Staff safety** initiatives have been introduced.

Recruiting/ Retaining: Staff **satisfaction** has been measured – and various strategies have been implemented to improve the quality of the workplace experience.

GOAL 4
A SUSTAINABLE, EFFICIENT, ACCOUNTABLE, QUALITY HEALTH SYSTEM.

Further discussion on the rational and explanation of the following Mandatory Dashboard indicators is provided in Appendix A:

Indicator		RHA Value	Provincial Value	Range	Target
Key activities undertaken by RHA to address public confidence reported *2006/2007* *[yes/no indicator]*	Q1	Yes	*not applicable*	*not applicable*	significant activity is expected annually, but need not be reflected quarterly
	Q2	Yes			
	Q3	Yes			
	Q4	Yes			

Indicator	RHA Value	Provincial Value	Range	Target
Percentage of surgical cases performed as day surgery[13] *2006/2007*	62.3%	56.3%	39.1% – 74.8%	*not applicable*

The goal of Saskatchewan Health is to increase the volumes of medically necessary procedures where patients are waiting excessively long times for surgery, in addition to managing wait lists in a more efficient manner in order to reduce the maximum wait time.

Potential to increase day surgery can be examined by investigating the day surgery rates for specific procedures in other regions. Within a region, examination of surgical cases with a length of stay of one or two days may indicate potential to move these surgeries to a day procedure setting. Coordination with community health services such as Home Care and Institutional Supportive Care may offer opportunities to move procedures from the inpatient to day surgery setting.

Client Centered Services: the region has initiated a **customer services** initiative through staff training and orientation sessions.

Quality: The region has introduced a new quality initiative named **Pursuing Excellence** – that examines services from the patient, resident, client's perspective and seeks to eliminate wasted steps and defects in the care and service delivery process.

Patient safety initiative such as a new sepsis protocol, stroke protocol, and trauma protocol have been implemented. The RHA has participated in the Safer Health Care Now initiative through these rapid response teams and the Health Quality Council sponsored ICU Collaborative.

Capital: plans for a **new wing** at Moose Jaw Union Hospital have been proposed.

FINANCIAL SUMMARY

Indicator	RHA Value	Provincial Value	Range	Target
Surplus (deficit) *2006/2007*	1,715,029	*not applicable*	$90,050-$7,861.926	$0
Number of days able to operate with working capital *2006/2007*	28.71	*not applicable*	(61.97)-28.71	*to be determined*
Expenditures in program support funding pool as a percentage of total RHA operating expenditures *2006/2007*	3.8%	*not applicable*	3.8%-10.5%	12% for Mamawetan Churchill River and Keewatin Yatthé; 5% for all other RHAs

The Five Hills Health Region continues to operate with an operating surplus which is transferred each year to the capital fund. These capital funds, along with foundation contributions, donations and provincial grants combine to allow the region to purchase necessary equipment and furnishings.

Future Outlook/ Emerging Issues

The region continues to operate within a balanced budget. Financial risks do exists due to the size and complexity of the organization. Operational variances may present through the wide breadth of programming, needs and related costs that emerge throughout the year. Capital infrastructure and equipment needs continue to be extensive and may present a challenge in future years – through urgent replacement mid-year.

On February 22nd, 2006 the Authority re-examined and established a set of strategic priorities for the Five Hills Health Region. The priorities of the Authority include:

- **Community Engagement** – Reinforcing the importance of community development
- **Client Centered Service** – providing exemplary customer service
- **Access** – reducing waitlists and wait times for service; exploring alternatives to deliver service closer to home or community.
- **Primary Health Care** – expanding primary health care sites and initiatives throughout the health region
- **Secondary Services** – supporting essential regional hospital and community hospital services
- **Quality** – pursuing excellence
- **Safety** – creating a safe environment for staff and those we serve
- **Population Health** – influencing those factors that make and keep us health.
- **Recruiting/retaining** – supporting a quality workplace and high performing work team.
- **Capital** – pursuing the new wing project at MJUH; exploring facility options for long term care delivery in future – in light of facility renewal requirements.

These strategic priorities are intended to bring focus to the organization. Quality, safety (patient and provider), disease prevention, community engagement, primary health care and chronic disease management will continue to be central themes in health care well into the future. Staffing and infrastructure will continue to be the prerequisites for service delivery.

A number of specific issues that emerge from our need assessment/health status information have been included on pages 23-25 of this report. Risks and risk domains have been summarized on page 9.

In addition to the aforementioned issues, a number of specific issues/opportunities have emerged that includes:

- **Hospitalization rates due to injury/falls** continue to be high. Readmission rates to the mental health inpatient unit will also need to be monitored and addressed.
- There continues to be **significant cost associated with staff sick time and wage driven premium hours.** The frequency of Workers Compensation claims continues to be a significant issue.

- Services will **need to become more responsive and flexible** in response to patient/resident/client centred approach.
- Care pathways, protocols, and algorithms will need to be further developed by providers to promote **greater standardization of interventions** that are based on best practice and evidence.
- **Capital renewal** for the future in acute and long term care will be required within the region – and in Moose Jaw in particular.

Governance and Transparency

The *Regional Health Services Act, 2002* established the responsibilities and powers of the Minister of Health and Regional Health Authorities.

Responsibilities and Powers of the RHA

Assess health needs
Develop operational plan
Provide health services
Evaluate health services
Promote health and wellness
Coordinate health services
Any other that the Minister may direct

RHA Committee Structure

The Five Hills Regional Health Authority has organized itself into the following Board Committees:

- Executive Committee
- Planning Committee
- Policy Committee
- Ethics Advisory Committee
- Mental Health and Addictions Services Advisory Committee

Public Transparency

To ensure public transparency the Five Hills Regional Health Authority has undertaken the following activities:

2006/2007 Regular Meetings held in a public forum:

April 26: Wood Mountain
May 31: Moose Jaw
June 28: Rouleau
August 30 – Moose Jaw
September 27 - Elbow
October 25 – Craik
December 20 – Moose Jaw
January 31, 2007 – Moose Jaw
March 28, 2007 – Moose Jaw

Internet site (www.fhhr.ca) content includes:

Minutes of the regular Authority meetings
2006-2009 Drug Strategy
2005-2006 Annual Report
2006 Strategic Priorities
2004-2005 Annual Report
2004-2005 Strategic Priorities
2003-2004 Annual Report
Strategic Plan
Strategic Plan September 2004 Update
Physician Resource Plan
Leadership Philosophy
Programs and Services
2005-2006 Health Status Report
Health Status Report 2002
2002 Child and Youth Needs Assessment
WNV Seroprevalence Report 2004
Surveys/Report 1999

- Senior Survey
- Adult Survey
- 0-5 Report

Community Advisory Structure

The Regional Health Services Act Section 28 states:

(1) A regional health authority shall establish one or more community advisory networks for the health region for the purpose of providing the regional health authority with advice respecting the provision of health services in the health region or any portion of the health region.

(2) The minister may provide directions to regional health authorities with respect to the establishment and composition of community advisory networks.

(3) Persons who participate in a community advisory network are not entitled to remuneration with respect to that participation.

Communities and organizations that our health region currently interacts includes but is not limited to the following:

Assiniboia Civic Improvement Association
Assiniboia Union Hospital Auxiliary
Badlands Recreational Committee
Briercrest College
Canadian Cancer Society
Canadian Diabetes Association
Cayer Trust (Willow Bunch)
Central Butte and District Foundation
Central Butte Union Hospital Auxiliary
Child Action Committee (Moose Jaw)
Child Action Group (Assiniboia)
Child and Youth Interagency Committee
Cosmo Senior Citizen's Centre
Craik and District Foundation
Craik Auxiliary
Department of National Defense – 15 Wing
Division scolaire francophone 310
Elbow Auxiliary
Emergency Measures Organizations
Emergency Response Planning Committee
Eyebrow Auxiliary
File Hills Tribal Council
Food Security Network
Grasslands Trust Fund Corp.
Grasslands Health Centre Auxiliary
Holy Trinity Roman Catholic Separate School Division No. 22
Housing Authorities
John Howard Society
Kincaid & District Health Centre Board Inc.
Lafleche District Health Foundation Inc.
Ludlow Trust
Medical Advisory Committee
Metis Nation
Moose Jaw & District Senior Citizens Association
Moose Jaw and District Interagency Committee
Moose Jaw Families for Change
Moose Jaw Health Foundation
Moose Jaw Mental Health Housing Committee
Moose Jaw Union Hospital Auxiliary
Mossbank Trust
Municipal Governments
Pioneer Lodge Assiniboia Auxiliary
Prairie South School Division No. 210
Regency Hospital Auxiliary
Regional Economic Development Authorities – Moose Jaw, Assiniboia, Red Coat
Regional Intersectoral Committee
Ross Payant Nursing Home Auxiliary
SIAST - Palliser Campus
South Central Recreation and Parks Association
South Country Health Care Foundation
Thunder Creek Rehabilitation Association
Transition House
Tugaske Auxiliary
Unions
Valley View Centre

The Five Hills Regional Health Authority has a network in place for receiving advice from a number and variety of communities. Primary Health Care development, with its significant community development component, will round out the existing network.

Payee List:

As part of government's commitment to accountability and transparency, the Department of Health and Regional Health Authorities disclose payments of $50,000 or greater made to individuals, affiliates and other organizations during the fiscal year. These payments include salaries, contracts, transfers, supply and service purchases and other expenditures.

FIVE HILLS REGIONAL HEALTH AUTHORITY
PAYEE DISCLOSURE LIST
For the Year Ended March 31, 2007

Personal Services

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more

Aasen, Dianne	$	69,571
Abramsen, Andrea		67,659
Ackerman, Linda		64,491
Adrian, Shelly		60,675
Albinet, Laurie		66,513
Alderton, Cheryl		53,612
Allen, James		68,575
Alraum, Isolde		67,672
Altwasser Bryant, Arla		59,176
Ambrose, Shelley		52,146
Amies, Michael		82,980
Anderson, Lori		54,542
Andrews Wittman, Melinda		69,466
Arseneau, Maureen		64,752
Awad El Kariem, Sawsan		298,690
Ayers, Nola		100,254
Bakke, Krista		63,220
Ballard, Gerry		78,286
Barnett, Krista		59,086
Barth, Darlene		54,155
Bastedo, J. Roger		65,129
Bauck, Deborah		73,571
Beaubien, Colette		63,637
Beesley, Craig		107,601
Bell, Kathy		52,816
Bender, Karen		60,395
Bengtson, Monica		62,163
Benoit, Ann		79,160
Benson, Lisa		62,234
Bergeron, Barbara		72,281
Bergeron, Christine		54,745
Berjian, Florence		64,620
Blatchford, Jenny		51,427
Blazieko, Joann		70,508
Blazieko, Wayne		110,422
Boerma, Lucinda		54,272
Bonneau, Shirley		57,708
Bonnor, Jim		60,848
Booth, Mary Lee		77,600
Boothman, Tami		63,620
Box, Kimberley		51,340
Boyajian, Elizabeth		70,095
Brenner, Teresa		56,807
Brisbin, Katherine		62,696
Broeder, Teresa		71,592
Brumwell, Mary		50,599
Buchanan, Robert		67,921
Budd Wutke, Darla		61,009
Bumphrey, Brenda		63,432
Burns, Maureen		65,344
Cameron, Marcy		60,086
Campbell, Shauna		63,055
Campbell, Wanda		69,900
Carretero, Antonio		184,260
Cayer, Janice		53,438
Chaisson, Alfred		54,032
Chaisson, Clara		67,672
Chokani, Ann-Marie		78,166
Chow, Amy		64,096
Claypool, Michele		50,419
Cobbe, Carmen		55,389
Cochrane, Rod		77,273
Cole, Brenda		52,381
Cooper, C. Cindy		51,398
Cotter, Debra		54,054
Cox, Sheila		68,689
Craig, Cheryl		114,674
Dancey, Colleen		62,772
Deringer, Gina		61,460
Dick, Denise		64,333
Dixon, Karen		64,518
Doepker, Bernie		54,107
Donley, Teresa		70,621
Dowling, Michelle		61,327
Dreger, Wanda		61,600
Driedger, Heather		59,793
Duncan, Nicole		59,883
Durand, Sylvia		71,441
Duzan, Nancy		55,325
Ebbett, Pamela		60,951
Eberts, Glynnis		69,094
Ellert, Clara M		58,540
Ellingson, Marie		66,570

Personal Services - Five Hills Health Region 2006/07

Ellingson, Michelle	61,894	Haque, Sameema	50,815
Engler, Kathryn	66,278	Hasmatali, Sheryl	67,500
Engstrom, Leslie	64,901	Haukaas, Brenda	69,830
Erickson, Sharon	55,725	Hayden, Janice	51,133
Ernest, Shirley	51,050	Hayes, Terra	50,955
Etches, Robert	323,709	Heath, Stacey	74,786
Farwell, Faye	60,621	Heilman, Louise	52,898
Ferguson, Dianne	99,008	Helland, Joanne	68,742
Ferguson, James	66,862	Hennenfent, Kandice	78,647
Fieldgate, Catherine	71,638	Hicks, Pat	71,987
Filipowich, Kathleen	67,672	Hollinger, Trish	56,294
Filomeno, Enrique	50,453	Huber, Marvin	64,711
Fitterer, Cheryl	60,954	Hudson, Donna	67,491
Fitzpatrick, Gail Jani	62,803	Hundeby, Janet	68,242
Fjeldberg, Rynae	68,703	Hutchinson, Terry	99,008
Flegel, Deborah	65,425	Ireland, Diane	83,072
Flegel, Elaine	56,704	Ireland, Sharon	62,717
Florizone, Dan	166,912	Jago, Terry	67,672
Flowers, Barbara	81,297	Jeffrey, Shannon	62,609
Forest, Diana	52,248	Johnson, Allyson	69,739
Forrest, Lois	74,097	Johnson, Cynthia	62,394
Fowler, Sandra	64,610	Johnson, Darren	61,106
Francoeur, Lisa	64,254	Johnson, Elaine	66,704
Frank, Gwenith	68,504	Johnson, Heather	61,988
Fraser, Dan	78,607	Johnson, Pamela	62,250
Freeman, Deborah	58,760	Johnson, Wayne	74,054
Froehlich, Kelly	62,397	Johnston Harper, Pauline	51,833
Fryklund, Susan	63,258	Johnston, Donna	55,525
Ganzer, Shelley	69,111	Josdal, Tyrone	115,451
Gareau, Rose	51,476	Juell, Jody	59,537
Gaucher, Adrien	83,855	Justason, Bernadett	57,541
Gee, Teresa	65,174	Karst, Teresa	72,275
Gleim, Sandra	60,350	Keall, Sylvia	66,227
Godin, Fairlie A.	62,512	Kergan, Guy	80,286
Good, Laune	73,879	Kien, Darlene	61,513
Goodison, Melonie	67,482	Kimball, Sandra	52,877
Goud, Dan	65,905	Kindrachuk, Joye	78,286
Goudie, Darlene	65,966	Kittler, Shelly	70,464
Grant, Mathilda	50,203	Kitts, Lynn	57,737
Green, Janice A.	58,743	Knudson, Katherine	58,712
Gregor, Carol	60,191	Konkin, Joan	56,888
Griffin, Kathy	65,887	Kowalski, Gwen	71,159
Guillaume, Allyson	64,480	Krepakevich, Kevin	78,286
Gummeson, Phyllis	69,146	Kwan, Beverley	55,140
Gyrlevich, Louise	65,840	Kwan, Rhonda	59,521
Hadley Cole, Rona	70,324	Lalonde, Janet	67,032
Hager, Brad	68,554	Lambert, Colleen	65,763
Haines, Michael	63,479	Langdon, Karyn	64,010
Handfield, Leslie	51,603	Lapointe, Shirley	59,881
Hanson, Teresa	56,777	Lavallee, Rose	54,315

Personal Services - Five Hills Health Region 2006/07

Law, Linda	67,735	Ogle, Wanda	64,568
Le Courtois, Robin	58,334	Oledzki, Joan	68,052
Lehmann, Karen	55,275	Oram, Dianne	58,034
Lewis, Shawna	60,675	Orban, Doreen	53,586
Liguori, John	99,008	O'Reilly, Audrey	83,980
Lind, Norma	65,441	Osemlak, Pauline	61,561
Longworth, Linda	54,800	Oxley, James	91,629
Longworth, Lorna	50,256	Pardy, Arlene	65,499
Lorencz, Therese	64,693	Paul, Connie	63,668
Lovick, Valerie K.	69,885	Paulhus, Tanis	58,972
Lowes, Joanne	64,505	Paull, Elizabeth	63,035
Macdiarmid, Joyce	67,756	Payant Oancia, Robbie	69,181
Mackenzie, Dawnidell	53,134	Pearson, Shannon	55,840
Macknak, Susan	78,286	Pecusik, Catherine	67,953
Manchuk, Sherry	54,847	Petersen, Joanne	53,044
Martyniuk, Bonita	67,376	Peterson, Eyvonne	62,467
McBride, Shirley	59,073	Peterson, Lance	62,360
McCormack, Evelyn C.	72,802	Petruic, Judy	51,356
McFadden, Brandy	61,382	Philipation, Dana	59,873
McGillivray, Kathyrn	66,443	Philipation, Travis	75,590
McGrath, Vicky	52,430	Pouteaux, Sarah	54,012
McInnes, Maryellen	68,949	Preston, Peggy	51,810
McIntosh, Les	66,925	Puckett, Lynn	67,075
McKenna, Jo-Ann	58,961	Reihl, Debbie	65,726
Menfield, Danielle	61,707	Remoue, Marilyn	57,828
Mielke, Janice	59,167	Rice, Christine	71,664
Miller, Gail	52,616	Richards, Tracy	53,826
Miller, Lenore	51,700	Roach, Shelley	68,912
Miller, Tamye	72,407	Robb, Donna	62,892
Mitchell, Don	66,653	Roberts, Christa	61,946
Mitchell, Muriel	77,018	Robertson, Jackie	64,942
Moffat, Christa	74,068	Rogers, Shannon	67,756
Molde, Helen L.	72,070	Rollie, Wendy	94,771
Molsberry, Marjorie	52,076	Rumancik, Peter	71,484
Montgomery, Marie Rose	66,796	Rusnak Weekes, Nicole	67,721
Moore, Isabel C.	69,846	Rusu, Troy	59,863
Morland, Darlene	71,992	Ruzicka Olson, Corie	55,810
Myers, Linda	53,743	Ryan, Beverley	81,150
Neal, Sheila	70,406	Sabourin, Dolores	67,765
Neigel, Darcy	67,603	Salaba, Janice	61,290
Newans, Robin	63,324	Saladana, Rita	53,628
Nicholl, Timothy	63,063	Salido, Deign	78,784
Nicholls, Brenda	66,008	Sanden, Wendy	58,124
Nicolay, Sheree	54,367	Sanders, Anita	94,088
Nicolson, Sharon	64,261	Sawers, Denise	50,269
Nouh, Mohamed	220,877	Schanoski, Paul	54,794
Ocrane, Sandra	51,911	Schnare, Gwen	50,697
Oen, Barb	51,940	Schoenau, Myrna	78,286
Ofstedahl, Donna	61,533	Scott, Deborah	71,211

Personal Services - Five Hills Health Region 2006/07

Segall, Heather	79,593
Seida, Norine	68,770
Shiers, Mark	64,648
Shirkey, Patti	73,042
Silljer, Robert	53,711
Silvester, Paul	72,322
Simmons, Lorna	60,513
Sinclair, Juliet A.	66,503
Sjoberg, Ellen	62,606
Smith, Anita	52,005
Smith, Brenda L.	65,536
Smith, Brenda S.	59,209
Smith, Charlene	54,806
Smith, Donna	52,608
Smith, Jessica	57,215
Smith, Marlene	53,169
Smith, Marylynn	115,201
Smith, Shelley	64,935
Sobottka, Bonnie	67,259
Sowden, Amanda	58,927
Sparks, Debbie	64,900
Spence, Laura	66,950
Spencer, Elaine	56,374
Stabell, Susan	55,336
Stankewich, Brenda	62,672
Stapor, Paul	71,321
Statham, Cheri	63,020
Stationwala, Ata	83,980
Steckhan, Edna	78,286
Steel, Brenda	65,332
Stenerson, Wade	63,024
Stevens, Debra	62,671
Stevenson, Nadine	68,159
Stewart, Cathy	64,261
Stobbs, John	65,043
Storozuk, Yvette	59,355
Strand, Chense	62,302
Strange, Debra	82,350
Straub, Carol	52,874
Straub, Jacquelin	70,789
Striha, Lynn	69,780
Strom, Shelda	57,316
Sullivan, Maureen	55,741
Swanson, Kerry	72,278
Switzer, Betty	67,167
Tendler, Cathy	56,700
Terry, Ernest	96,399
Theede, Maryanne	84,382
Thompson, Marcie	58,888
Thul, Lori	64,123
Tkachuk, Brian	70,374
Treleaven, Shelly	63,706
Trusty, Alice	65,394
Tysdal, Elizabeth	52,820
Ullrich, Landon	50,489
Urquhart, Debra	66,521
Vaessen, Leisa	67,737
Velecky, Laura	57,189
Vetter, Lorraine	53,319
Vooght, Mark	193,228
Waldenberger, Vanessa	62,233
Walker, Vivian	50,768
Wanner, Brian	66,796
Ward, Cheryl	67,092
Warren, Barbara	65,189
Warsi, Mohammed	337,652
Wasylenka, Dixie	67,658
White, Patricia	55,390
Wicharuk, Judy	61,142
Wiebe, Merilee	57,837
Willatt, Linda	61,655
Williams, Kathryn	54,031
Williams, Shannon	71,283
Wilm, Joanne	70,856
Winkler, Lucyna	66,835
Wittal, Gerrilynn	69,510
Wohlberg Knelsen, Sharon	59,511
Wolfe, Jacquelin	67,845
Woloschuk Connor, Laurie	60,058
Wong, Gail	56,025
Wood, Darcy	63,817
Work, Jodi	65,406
Wozniak, Yvonne	63,326
Yost Walter, Lynda	66,796
Zarubin, Amanda	51,059
Payees under $50,000	26,097,738
Total Personal Services	$ 51,107,445

Transfers

Listed, by program, are transfers to recipients who received $50,000 or more.

Extendicare	$	5,259,325
Individualized Home Care Funding		139,115
Moose Jaw & District EMS		1,182,570
Moose Jaw Alcohol & Drug Abuse		778,126

Transfers - Five Hills Health Region 2006/07

Providence Place	10,341,197
St Joseph's EMS Gravelbourg	200,001
St Joseph's Hospital Gravelbourg	3,689,788
Thunder Creek Rehab Assoc Inc.	367,151
Wald Ambulance 0752932004	460,304
	$ 22,417,577

Supplier Payments

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts and equipment.

Abbott Laboratories Ltd.	$ 429,694
Al-Begamy, Dr. Youssef	231,585
Alcon Canada Inc.	343,330
AMT Electrosurgery	53,189
Arjo Canada Inc.	271,770
Brennan Office Plus	59,948
Bunzl Canada	158,332
Can-Med Healthcare	88,222
CEG Energy Options Inc.	606,381
Christie Group Ltd.	166,507
City Of Moose Jaw	128,754
CPDN - 3130827 Canada Inc.	565,208
CU Credit Mastercard	76,258
De Coteau, Dr. W. Earle	56,966
Du Toit, Awie Radiology Prof. Corp.	781,485
Ecolab Ltd.	59,262
Eecol Electric (Sask) Ltd.	66,279
Fiber Tech	85,961
Futuremed Health Care Products	58,582
Gambro Inc.	71,499
Geyer, Dr. Willem J.	57,592
Glaeske, Dr. Daniel	53,615
Great West Life Assurance Company	361,645
Health Sciences Assoc Of Sask	63,381
Heilman, James Medical Prof Co.	289,194
Hospira Heathcare Corp	355,931
Johnson & Johnson Medical	144,396
Johnson Controls Ltd. #C3039	65,237
Jump.Ca	110,521
Kruger, Dr. Johan	156,250
Lean Advisors Inc.	60,096
Leeuw, Dr. Gary	56,479
London Life	59,445
Luhning, Dr. Allan	55,221
Marsh Canada Limited	200,867
Marx, Dr. Yolanda	195,713
Mckesson Canada	364,046
Minister Of Finance Saskatchewan	619,099
Momentum Healthware	266,658
Moose Jaw & District EMS	119,610
Moose Jaw Transition House	184,989
Olufowobi, Dr. Olufemi O.	130,118
Pansegrouw, Dr. Sandra	225,831
Pantazopoulos, Dr. George	104,824
Philips Electronics Ltd.	153,026
Prairie Janitorial Supply	78,598
Pretorius, Dr. Juan Marco	197,257
Provincial Medical Supplies	50,837
Public Employees Pension Plan	187,622
Ramadan, Dr. Fauzi F.	54,675
Receiver General For Canada	18,481,367
Rossouw, Dr. Stephanus	86,040
SAHO	359,309
SAHO Dental Plan	500,296
SAHO Dip	1,547,333
SAHO Extended Health & Dental	1,840,650
Sanderson, Dr. Brian J.	75,680
Saputo Foods Limited	128,161
Sask Energy	327,372
Sask Health Information Network	394,042
Sask Power	966,489
Sask Registered Nurses Association	129,205
Sask Tel CMR	211,183
Sask Tel Mobility	60,372
Sask Workers' Compensation Board	1,431,407
Schaan Healthcare Products Inc.	806,050
Security Patrol & Investigators	88,281
SEIU Local 299 MJ	526,771
Shanthakumar, Dr. Ratnasingham	58,180
SHEPP	6,290,750
Source Medical	240,525
St. Joseph's Hospital Gravelbourg	247,250
Steris Canada Inc.	88,508
Stevens Company Limited	195,976
Stryker Canada Inc.	98,769
Sun Provincial	273,347
Sunspun Food Service	523,778
Supreme Office Products Ltd.	196,393
Sysco Food Services	438,660
Thorpe, Dr. R. Brandon	52,045
Thunder Creek Rehab Association Inc.	228,571
Truter, Dr. Rene	80,121
Tyco Healthcare Group Canada	207,543
Valley View Centre	950,947

Supplier Payments - Five Hills Health Region 2006/07

Van Wyk, Dr. Gerrit Prof Corp	375,783
Zimmer Of Canada Ltd.	128,379
Supplier Payments under $50,000	6,495,115
	$ 54,512,633

Performance Management Summary (Indicator Tables)

In support of *The Action Plan for Saskatchewan Health Care,* Saskatchewan Health developed an *accountability framework* and accountability documents with each health region that define and clarify the performance relationship between the authorities and the province. In addition to articulating organizational and program expectations of the RHAs, the accountability documents also link these expectations with funding and with performance indicators-measures of progress towards, and achievement of, the expectations.

To demonstrate accountability and transparency to the public, these indicators are publicly reported through this summary table in each region's annual report. For further information on technical interpretations and definitions of the indicators below refer to the *Performance Management* document on the Saskatchewan Health website at www.health.gov.sk.ca.

Indicator		RHA Value	Provincial Value	Range	Target
Organizational Effectiveness Indicators					
Quality					
Date of last CCHSA accreditation or when accreditation is scheduled *as of March 2007*		November 2005	*not applicable*	*not applicable*	*to be determined*
Date when the RHA participated in the Institute for Safe Medication Practices (ISMP) Canada "Hospital Medication Safety Self-Assessment", or when participation is planned *as of March 2007*		May 19, 2005	*not applicable*	*not applicable*	*to be determined*
Number of client contacts with the Quality of Care Coordinator to raise a concern *2005/2006*		248	*not applicable*	*not applicable*	*not applicable*
Percentage of concerns raised with a Quality of Care Coordinator concluded within 30 days *2005/2006*		83%	86%	66% – 99%	*to be determined*
Workforce Planning					
The number of positions sitting vacant for periods longer than six months *[indicator to be developed]*		——	——	——	——
Distribution of health system full time equivalents (FTEs) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	800.43	*not applicable*	*not applicable*	*not applicable*
	HSAS	71.88			
	OOS/OTHER[1]	107.70			
	SUN	256.40			

Indicator		RHA Value	Provincial Value	Range	Target
	RWDSU[2]	*not applicable*			
	Organization as a whole	1,236.41			
Number of wage-driven premium hours (overtime and other premiums) per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	19.61	36.85	16.36 – 91.10	*to be determined*[3]
	HSAS	8.89	25.44	0.25 – 117.97	*to be determined*[3]
	OOS/OTHER[1]	1.37	3.46	0.00 – 16.92	*to be determined*[3]
	SUN	27.14	81.54	27.14 – 368.66	*to be determined*[3]
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*to be determined*[3]
	Organization as a whole	18.96	42.47	17.19 – 131.56	*to be determined*[3]
Worked hours as a percentage of total hours by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	79.6%	78.3%	73.1% – 80.7%	*to be determined*[3]
	HSAS	82.8%	80.8%	75.0% – 83.9%	*to be determined*[3]
	OOS/OTHER[1]	82.8%	82.5%	76.4% – 84.5%	*to be determined*[3]
	SUN	77.9%	74.7%	63.7% – 77.9%	*to be determined*[3]
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*to be determined*[3]
	Organization as a whole	79.7%	78.1%	72.5% – 80.7%	*to be determined*[3]
Number of sick leave hours per full time equivalent (FTE) by affiliation *2006/2007*	Provider Unions (CUPE, SEIU, SGEU)	89.43	89.78	71.62 – 107.61	*to be determined*[3]
	HSAS	51.04	65.62	44.65 – 92.53	*to be determined*[3]
	OOS/OTHER[1]	47.00	47.34	27.68 – 61.46	*to be determined*[3]
	SUN	81.10	89.34	63.83 – 96.84	*to be determined*[3]
	RWDSU[2]	*not applicable*	*not applicable*	*not applicable*	*to be determined*[3]
	Organization as a whole	81.77	84.12	64.15 – 93.63	*to be determined*[3]
Number of lost-time WCB claims per 100 full time equivalents (FTEs) *2006/2007*		5.90	7.67	0.53 – 10.00	*to be determined*[3]

Indicator		RHA Value	Provincial Value	Range	Target
Number of lost-time WCB days per 100 full time equivalents (FTEs) *2006/2007*		630.54	468.45	38.43 – 766.40	*to be determined*[3]
Percentage of employees self-identifying as Aboriginal *2005/2006*[4]		*not applicable*	*not available*	*not applicable*	*to be determined*
Number of clinical placements offered and taken within the region / SCA *[indicator to be developed]*		———	———	———	———
Financial					
Surplus (deficit) *2006/2007*		1,715,029	*not applicable*	$90,050 – $7,861,926[29]	$0
Surplus (deficit) as a percentage of actual operating expenditures *2006/2007*		1.7%	*not applicable*	0.1% – 9.0%[29]	0.0% – 0.5%
Working capital ratio (current ratio) *2006/2007*		1.60	*not applicable*	0.23 – 1.81[29]	*to be determined*
Number of days able to operate with working capital *2006/2007*		28.71	*not applicable*	(61.97) – 28.71[29]	*to be determined*
Communications and Issues Management					
Key activities undertaken by RHA to address public confidence reported *2006/2007* *[yes/no indicator]*	Q1	Yes	*not applicable*	*not applicable*	significant activity is expected annually, but need not be reflected quarterly
	Q2	Yes			
	Q3	Yes			
	Q4	Yes			
Capital					
Annual equipment maintenance costs as a percentage of annual equipment replacement costs *[indicator to be developed]*		———	———	———	———
Program-Specific Indicators					
Province-Wide Services					
Number of patients as a percentage of agreed on target for magnetic resonance imaging (MRI) services[5] *2006/2007*		*not applicable*	102.4%	101.2% – 103.3%	100%
Number of exams as a percentage of agreed on target for magnetic resonance imaging (MRI) services[5] *2006/2007*		*not applicable*	90.6%	85.9% – 93.1%	100%

Indicator		RHA Value	Provincial Value	Range	Target
Number of actual hours of operation for magnetic resonance imaging (MRI) services[5] *2006/2007*		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Number of patients as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*		103.7%	98.0%	93.5% – 111.0%	100%
Number of exams as a percentage of agreed on target for computed tomography (CT) services[6] *2006/2007*		99.6%	107.3%	73.5% – 125.6%	100%
Number of actual hours of operation for computed tomography (CT) services[6] *2006/2007*		2012	*not applicable*	*not applicable*	*to be determined*
Number of patients as a percentage of agreed on target for bone mineral densitometry (BMD) services[5] *2006/2007*		*not applicable*	90.5%	78.4% – 101.7%	100%
Number of actual hours of operation for bone mineral densitometry (BMD) services[5] *2006/2007*		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Number of patient years of dialysis provided in the current fiscal year[7] *2006/2007*		11.94	*not applicable*	*not applicable*	*to be determined*
Current fiscal year's chronic kidney disease services levels as compared to previous fiscal year's levels[8] *As at December 31, 2006*	Number of chronic renal insufficiency patients	*not applicable*	*not applicable*	*not applicable*	*to be determined*
	Number of peritoneal dialysis patients				
	Number of home unit chronic hemodialysis patients				
	Number of north/south chronic hemodialysis patients				
Average wait time for admission to Saskatchewan Hospital North Battleford (SHNB)[9] *2005/2006*		*not applicable*	*not applicable*	*not applicable*	*to be determined*

Indicator		RHA Value	Provincial Value	Range	Target
Length of stay efficiency of inpatient rehabilitation programs – Wascana Rehabilitation Centre and Saskatoon City Hospital[10,11] *2005/2006*	Stroke	*not applicable*	*not applicable*	*not applicable*	*to be determined*
	Brain Dysfunction				
	Spinal Cord Dysfunction				
	Orthopaedic Conditions				
	Neurological Conditions				
	Amputation of Limb				
	Major Multiple Trauma				
	Medically Complex				
	Debility				
	Cardiac				
	Pulmonary				
	Arthritis				
	Pain Syndrome				
	Other	*			
Alcohol and drug inpatient treatment completion rate per 100 admissions – Calder Centre[12] *2005/2006*	Child / Youth	88.9%	*not applicable*	*not applicable*	*to be determined*
	Adult	75.0%			
Acute Care					
Percentage of surgical cases performed as day surgery[13] *2006/2007*		62.3%	56.3%	39.1% – 74.8%	*not applicable*
Number and percentage of surgical cases on wait list that have already waited over 12 months[13] *2006/2007*	Number	33	*not applicable*	*not applicable*	*not applicable*
	Percentage	3.8%	19.9%	0.0% – 23.8%	10%
Number and percentage of surgical cases on wait list that have already waited over 18 months[13] *2006/2007*	Number	*	*not applicable*	*not applicable*	*not applicable*
	Percentage	*	9.5%	0.0% – 12.0%	0%
	* indicates that the data originally in the cell was suppressed in order to protect privacy. The data either did not meet the required threshold of "more than 5", or it can be used to derive data in a cell that would not meet this requirement. Suppression is maintained in publication of these tables.				

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of Priority Level I, II, III and IV surgical cases completed within target time frames[13] *2006/2007*	Priority Level I within 3 weeks	78.8%	57.3%	43.7% – 97.4%	95%
	Priority Level II within 6 weeks	61.9%	43.8%	0.0% – 96.6%	90%
	Priority Level III within 3 months	86.6%	63.9%	43.3% – 100.0%	90%
	Priority Level IV within 12 months	97.4%	88.0%	79.3% – 100.0%	90%
Cumulative number of surgical cases performed as a percentage of target and variance from target[13] *2006/2007*	Percentage of target	98.9%	98.3%	85.2% – 122.4%	100%
	Variance from target	-42	*not applicable*	*not applicable*	*not applicable*
Institutional Supportive Care					
Average wait time between approval for placement and placement for institutional supportive care services *[indicator to be developed]*		———	———	———	———
Prevalence of pressure sores: percentage of institutional supportive care residents with pressure sores[14] *as at the end of Q2 2006/2007*		16.47%	21.94%	16.47% – 28.28%	*to be determined*
Case mix index for institutional supportive care facilities[14] *as at the end of Q2 2006/2007*		0.763	0.771	0.725 – 0.800	*to be determined*
Home-Based Supportive Care					
Case mix index for supportive home care services *[indicator to be developed]*		———	———	———	———
Average wait time between referral and assessment for supportive home care services *[indicator to be developed]*		———	———	———	———
Average wait time between assessment and commencement of supportive home care services *[indicator to be developed]*		———	———	———	———
Population Health Services					
Percentage of off reserve schools that are implementing health food nutrition policies *as of September 1, 2006*		7.8%	*not applicable*	0.0% – 27.3%	60% of schools by September 2011
Exclusive breastfeeding rates[15] *2005*		29.34%	21.28%	13.64% – 40.11%	*to be determined*

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of eligible population registered in SIMS and receiving recommended immunization at second birthday[16] *July 1, 2005 to June 30, 2006*	Diphtheria	82.1%	73.5%	50.0% – 87.2%	*to be determined*
	Measles	80.4%	72.5%	67.9% – 86.1%	
Influenza immunization rate per 100 population (age 65 years and over) *2005/2006*		67%	66%	46% – 77%	*to be determined*
Percentage of licensed or regulated facilities inspected each year (pursuant to *The Public Health Act*) *2005/2006 and 2006/2007*	FEE – Food Eating Establishment	99%	*not applicable*	45% – 100% 71% – 100%	80% – 100%
	FPL – Food Processing (Licensed)	100%	*not applicable*	20% – 100% 67% – 100%	
	LA – Licensed Accommodations	99%	*not applicable*	31% – 100% 52% – 100%	
	SP – Swimming Pools	98%	*not applicable*	43% – 100% 45% – 100%	
	Public Water Supplies	95%	*not applicable*	20% – 100% 18% – 100%	
Percentage of genital chlamydia cases with complete or required surveillance information in the electronic provincial surveillance system within established time frames *[indicator to be developed further]*		———	———	———	———
Percentage of facilities in compliance with *The Tobacco Control Act* in the category that includes: billiard halls / bingo establishments / bowling centres / casinos / restaurants / taverns *[data is currently not available due to system implementation issues]*		———	———	———	90% compliance
Percentage of population (age 12 years and over) who are current (daily or occasional) smokers[15] *2005*	Males	25.01%	25.13%	19.95% – 41.75%	*to be determined*
	Females	20.18%	23.30%	16.36% – 32.31%	
Community Care Services					
Average wait time between initial contact and first face-to-face contact for outpatient child and youth mental health services *[indicator to be developed]*		———	———	———	———

Indicator	RHA Value	Provincial Value	Range	Target
Average wait time between initial contact and first face-to-face contact for outpatient adult community mental health services *[indicator to be developed]*	———	———	———	———
Average wait time between initial contact and first face-to-face contact for outpatient psychiatric rehabilitation mental health services *[indicator to be developed]*	———	———	———	———
Alcohol and drug outpatient treatment completion rate per 100 admissions *2005/2006*	58.4%	59.7%	41.8% – 72.2%	*to be determined*
Average wait time for admission to alcohol and drug outpatient services *[data not available]*[17]	———	———	———	———
Problem gambling treatment completion rates per 100 admissions *[indicator to be developed]*	———	———	———	———
Home-Based Acute and Palliative Care				
Average wait time between referral and assessment for acute and palliative home care services *[indicator to be developed]*	———	———	———	———
Average wait time between assessment and commencement of home-based acute and palliative care *[indicator to be developed]*	———	———	———	———
Percentage of palliative home care clients with unresolved pain *[indicator to be developed]*	———	———	———	———
Percentage of palliative home care clients who choose to die at home and receive services in support of that option *[indicator to be developed]*	———	———	———	———
Percentage of patients discharged from acute care to home care with post-acute discharge plan in place on discharge *[indicator to be developed]*	———	———	———	———
Primary Health Services				
Percentage of RHA population with geographic proximity to primary health care teams *March 2007*	4.99%	19.98%	0.00% – 100.00%	25% of SK residents by 2006, 100% by 2011

Indicator		RHA Value	Provincial Value	Range	Target
Number of discrete clients receiving primary health care services in the RHA *2006/2007*	Q1	1054	*not applicable*	*not applicable*	*not applicable*
	Q2	1087			
	Q3	1083			
	Q4	966			
Number of Healthline calls for the RHA *2006/2007*	Q1	1082	*not applicable*	*not applicable*	*not applicable*
	Q2	846			
	Q3	849			
	Q4	1213			
	Year as a whole	3990			
Total number of new primary health care teams developed in the current year *2006/2007*		0	*not applicable*	*not applicable*	*not applicable*
Emergency Response Services					
Percentage of calls where the maximum qualification of all personnel on the call was less than Emergency Medical Technician (EMT) *2005/2006*		0.08%	0.73%	0.00% – 17.97%	*to be determined*
Mental Health and Addiction Services					
Average length of stay of mental health inpatients[18] *2005/2006*		11.9	15.4	10.1 – 19.8	*to be determined*
Mental health inpatient readmission rate per 100 mental health inpatients[18] *2005/2006*		23.4%	20.9%	18.4% – 25.7%	*to be determined*
Alcohol and drug inpatient treatment completion rate per 100 admissions[19] *2005/2006*		*not applicable*	69.1%	55.9% – 72.6%	*to be determined*
Average wait time for admission to alcohol and drug inpatient services[20] *February and March 2007*[17]		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug detoxification services[21] *February and March 2007*[17]		5.2 days	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug stabilization services[22] *February and March 2007*[17]		*not applicable*	*not applicable*	*not applicable*	*to be determined*
Average wait time for admission to alcohol and drug long term residential treatment services[23] *[data not available]*[17]		———	———	———	———

Indicator		RHA Value	Provincial Value	Range	Target
Program Support Services					
Expenditures in program support funding pool as a percentage of total RHA operating expenditures *2006/2007*		3.8%	*not applicable*	3.8% – 10.5%[28]	12% for Mamawetan Churchill River and Keewatin Yatthé; 5% for all other RHAs
Health Status and Outcome Indicators					
Infant mortality rate per 1,000 live births[24] *2002-2004*		9.1	5.9	4.0 – 10.5	*to be determined*
Low birth weight rate per 100 live births[24] *2002-2004*		5.2	5.4	3.7 – 6.0	*to be determined*
High birth weight rate per 100 live births[24] *2002-2004*		14.0	15.7	12.9 – 31.1	*to be determined*
Potential years of life lost per 100,000 population (age 0 to 74 years)[15] *2001*[25]	Circulatory Diseases	1145.3	951.5	817.9 – 1,208.9	*to be determined*
	All Malignant Neoplasms	1554.9	1,483.1	1,126.0 – 1,706.8	
	All Respiratory Diseases	307.6	222.9	63.5 – 376.5	
	Unintentional Injuries	663.4	1,028.0	636.4 – 2,781.8	
	Suicide and Self-Inflicted Injuries	396.3	412.1	315.1 – 628.5	
Disability-free life expectancy (at birth)[15] *1996*[25]	Males	66.5	66.6	61.8 – 69.2	*to be determined*
	Females	69.8	70.0	63.2 – 72.5	
Disability-free life expectancy (at age 65 years)[15] *1996*[26]	Males	11.2	11.2	8.7 – 12.1	*to be determined*
	Females	12.7	12.7	8.4 – 13.2	
Life expectancy (at birth)[15] *2001*[27]	Males	75.7	76.2	72.1 – 78.2	*to be determined*
	Females	81.6	81.8	76.1 – 82.8	
Life expectancy (at age 65 years)[15] *2001*[27]	Males	16.2	16.9	15.6 – 18.0	*to be determined*
	Females	20.6	20.9	17.2 – 21.8	
Self-rated health status: percentage of population (age 12 years and over) who report their health as very good or excellent[15] *2005*		55.69%	52.35%	39.86% – 57.96%	*to be determined*

Indicator		RHA Value	Provincial Value	Range	Target
Percentage of population (age 18 to 64 years) who are overweight or obese[15] *2005*	Overweight (BMI 25.0-29.9)	32.74%	32.52%	30.53% – 36.12%	*to be determined*
	Obese (BMI 30.0+)	18.33%	20.03%	16.88% – 24.19%	
Percentage of population (age 12 years and over) who report physical activity participation levels of active / moderately active or inactive[15] *2005*	Active / moderately active	46.44%	48.62%	38.60% – 53.35%	*to be determined*
	Inactive	51.25%	49.52%	44.06% – 58.77%	
Number of visits to a physician for a mental health reason *2005/2006*	General Practitioners	20,853	*not applicable*	*not applicable*	*not applicable*
	Psychiatrists	1,051			
Age-sex-adjusted diabetes prevalence rate per 1,000 population[28] *2004/2005*		53.8	*not applicable*	41.8 – 95.8	*to be determined*
Injury hospitalization rate per 1,000 population (age 0 to 19 years) *2004/2005*	Males	13.4	10.4	7.3 – 27.0	*to be determined*
	Females	7.3	6.9	4.8 – 12.9	
Hospitalization rate due to falls per 1,000 population (age 65 years and over) *2004/2005*	Males	16.1	14.7	10.5 – 22.0	*to be determined*
	Females	29.9	26.6	19.9 – 38.0	

Notes:

Please refer to the document "Performance Management Accountability Indicators" for detailed indicator descriptions.

1 The OOS/OTHER category includes all non-unionized employees on the SAHO Payroll system, not just management personnel.

2 The RWDSU category is applicable to Regina Qu'Appelle only.

3 Benchmark development is still in progress for the workforce planning indicators. In the interim, it is suggested that the provincial value or that of the best performer be used as the target.

4 The most recent data for the "Percentage of employees self-identifying as Aboriginal" indicator is from 2005/2006, and is not available for Five Hills, Cypress, Heartland, Prairie North, the Saskatchewan Cancer Agency, or the province as a whole.

5 MRI and bone mineral densitometry indicators are applicable to Regina Qu'Appelle and Saskatoon only.

6 CT indicators are applicable to Cypress, Five Hills, Prairie North, Prince Albert Parkland, Regina Qu'Appelle, Saskatoon, and Sunrise only.

7 Patient years of dialysis indicator is applicable to Cypress, Five Hills, Regina Qu'Appelle, Saskatoon, Kelsey Trail, Prairie North, Prince Albert Parkland, and Sunrise only.

8 Chronic kidney disease services indicator is applicable to Regina Qu'Appelle and Saskatoon only.

9 SHNB indicator is applicable to Prairie North only.

10 "Length of stay efficiency of inpatient rehabilitation programs" indicator is applicable to Regina Qu'Appelle (Wascana Rehabilitation Centre) and Saskatoon (Saskatoon City Hospital) only.

11 Wascana Rehabilitation Centre and Saskatoon City Hospital are not peer facilities, in terms of their inpatient rehabilitation programs. Therefore, their results should not be compared to each other.

12 "Alcohol and drug inpatient treatment completion rate – Calder Centre" is applicable to Saskatoon only.

13 The 2006/2007 target volume of surgeries to be performed by each RHA was negotiated between that RHA and Saskatchewan Health.

14 Due to the small number of institutional supportive care residents in Mamawetan Churchill River and Keewatin Yatthé, the case mix index and pressure sores indicators are not applicable to these regions.

15 Mamawetan Churchill River, Keewatin Yatthé and Athabasca Health Authority were grouped together as "Northern Health Regions" for this indicator.

16 The Saskatchewan Immunization Management System (SIMS) does not capture on-reserve immunizations.

17 Data collection through the Alcohol and Drug Client Information System (ADCIS) will start in April 2007. Results for alcohol and drug inpatient, detoxification, and stabilization services are based on data collected manually in February and March 2007 (Saskatoon detoxification data available for March 2007 only).

18 Mental health inpatient indicators are not applicable to Heartland, Keewatin Yatthé, Kelsey Trail, and Mamawetan Churchill River.

19 "Alcohol and drug inpatient treatment completion rate" is applicable to Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Regina Qu'Appelle, and Saskatoon only.

20 "Average wait time for admission to alcohol and drug inpatient services" is applicable to Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Prince Albert Parkland (youth services), Regina Qu'Appelle, and Saskatoon (both adult and youth services) only.

21 "Average wait time for admission to alcohol and drug detoxification services" is applicable to Five Hills, Keewatin Yatthé, Mamawetan Churchill River, Prairie North, Regina Qu'Appelle, and Saskatoon only.

22 "Average wait time for admission to alcohol and drug stabilization services" is applicable to Regina Qu'Appelle and Saskatoon only.

23 "Average wait time for admission to alcohol and drug long term residential treatment services" is applicable to Prairie North only.

24 Starting 2005/2006, the calculation methodology for the "Infant mortality rate", "Low birth weight rate" and "High birth weight rate" indicators changed from what was used previously. The time period also changed (three consecutive years, instead of five). Because these measures are calculated on a three-year basis, results are the same as those reported in 2005/2006.

25 Statistics Canada calculates this measure intermittently. The most recent is based on 2000 through 2002 death data and 2001 population estimates. Therefore, results are the same as those reported for 2005/2006.

26 Statistics Canada no longer calculates this measure (a similar measure, "Health Adjusted Life Expectancy (HALE)", exists but is not available at the regional level). Therefore, results are the same as those reported for 2004/2005 and 2005/2006.

27 Statistics Canada calculates this measure every 5 years, based on the latest census (2001). Therefore, results are the same as those reported for 2004/2005 and 2005/2006.

28 Starting 2005/2006, diabetes cases are determined using an enhanced version of the methodology (the prescription drug database is now used along with the hospital separations and physician services databases). Caution should be exercised if comparing results to those presented in the 2004/2005 summary. The age-sex-adjusted rates were calculated using 1996 Statistics Canada Census populations for Saskatchewan by sex and ten-year age groups.

29 Range values are based on data from final, unaudited financial statements.

Management Report

June 15, 2007

FIVE HILLS HEALTH REGION
REPORT OF MANAGEMENT

The accompanying financial statements are the responsibility of management and are approved by the Five Hills Regional Health Authority. The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity include amounts based on estimates and judgments. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority is responsible for reviewing the financial statements and overseeing Management's performance in financial reporting. The Authority meets with Management and the external auditors to discuss and review financial matters. The Authority approves the financial statements and the annual report.

The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Regional Health Authority. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Dan Florizone
Chief Executive Officer

Wayne Blazieko
Chief Financial Officer

2006-07 Financial Report

Canadian Generally Accepted Auditing Standards require the auditor appointed by the RHA review the annual report prior to release. The auditor's review is to ensure the financial statements and auditor's reports are adequately reproduced, and to ensure any other information presented within the report is consistent with the financial statements. Once the auditor has reviewed the annual report and determined it is accurate, they will provide the RHA with permission to include their signature in the annual report.

VIRTUS GROUP

Chartered Accountants & Business Advisors LLP

AUDITORS' REPORT

To the Five Hills Regional Health Authority

We have audited the statement of financial position of the Five Hills Regional Health Authority as at March 31, 2007 and the statements of operations and changes in fund balances and cash flow for the year then ended. These financial statements are the responsibility of the Authority's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial information.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Five Hills Regional Health Authority as at March 31, 2007 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Regina, Saskatchewan
May 11, 2007

Virtus Group LLP
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FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2007

	Operating Fund	Restricted Funds: Capital Fund	Restricted Funds: Community Trust Fund	Total 2007	Total 2006 (Note 10)
ASSETS					
Current assets					
Cash and short-term investments (Statement 3)	$ 11,488,652	$ 6,870,336	$ 236,275	$ 18,595,263	$ 14,894,313
Accounts receivable					
Saskatchewan Health - General Revenue Fund	498,609	-	-	498,609	2,744,968
Other	774,480	41,142	13,527	829,149	869,294
Inventory	810,918	-	-	810,918	786,530
Prepaid expenses	1,106,386	-	-	1,106,386	858,852
	14,679,045	6,911,478	249,802	21,840,325	20,153,957
Investments (Market $1,660,870; 2006 - $1,323,837)	79,124	613,861	852,206	1,545,191	1,188,657
Capital assets (Note 3)	-	20,776,409	-	20,776,409	23,918,640
Total Assets	$ 14,758,169	$ 28,301,748	$ 1,102,008	$ 44,161,925	$ 45,261,254
LIABILITIES & FUND BALANCE					
Current liabilities					
Accounts payable	$ 4,002,351	$ 12,793	$ -	$ 4,015,144	$ 4,659,665
Accrued salaries	1,902,096	-	-	1,902,096	3,325,497
Vacation payable	4,805,303	-	-	4,805,303	4,401,482
Mortgages payable – Current (Note 5)	-	100,033	-	100,033	90,542
Deferred Revenue (Note 6)	2,820,517	-	-	2,820,517	2,203,997
	13,530,267	112,826	-	13,643,093	14,681,183
Long Term Liabilites					
Long Term Leases Payable	-	-	-	-	-
Mortgages payable (Note 5)	-	2,122,865	-	2,122,865	2,224,721
Total Liabilities	13,530,267	2,235,691	-	15,765,958	16,905,904
Fund Balances (Statement 2)					
Invested in capital assets	-	18,553,512	-	18,553,512	21,603,377
Externally restricted (Schedule 3)	-	-	1,102,008	1,102,008	1,085,636
Internally restricted (Schedule 4)	5,793	701,002	-	706,795	676,337
Unrestricted	1,222,109	6,811,543	-	8,033,652	4,990,000
Fund balances – (Statement 2)	1,227,902	26,066,057	1,102,008	28,395,967	28,355,350
Total Liabilities & Fund Balances	$ 14,758,169	$ 28,301,748	$ 1,102,008	$ 44,161,925	$ 45,261,254

Approved on behalf of the board of directors:

See accompanying notes to the Financial Statements.

Statement 2

FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2007

	Operating Fund			Restricted			
	Budget 2007	2007	2006 (Note 10)	Capital Fund 2007	Community Trust Fund 2007	Total 2007	Total 2006 (Note 10)
REVENUES							
Saskatchewan Health - General Revenue	$ 93,445,143	$ 94,963,910	$ 90,155,392	$ 1,372,839	$ -	$ 1,372,839	$ 1,168,594
Other Provincial Revenue	371,305	332,182	341,206	52,688	-	52,688	57,843
Federal Government Revenue	89,809	89,411	99,426	-	-	-	-
Funding from other Provinces	-	-	-	-	-	-	-
Special Funded Programs	770,791	742,660	731,016	-	-	-	-
Patient Fees	3,301,789	3,391,049	3,249,431	-	-	-	-
Out of Province Revenue (Reciprocal)	496,300	558,198	495,894	-	-	-	-
Out of Country Revenue	50,900	57,088	51,192	-	-	-	-
Donations	40,000	151,838	53,502	538,310	-	538,310	266,339
Investment Revenue	305,700	603,102	364,090	234,081	48,342	282,423	194,202
Ancillary Revenue	147,700	149,375	146,756	20,660	-	20,660	20,660
Recoveries	1,108,305	1,536,603	1,283,151	-	-	-	-
Other Revenue	18,355	25,906	35,495	53,333	-	53,333	50,673
	100,110,474	102,591,362	97,063,545	2,271,851	48,342	2,320,193	1,758,094
EXPENSES							
Province Wide Acute Care Services	1,213,009	1,124,327	975,807	-	-	-	-
Acute Care Services	35,451,044	36,002,420	35,883,078	2,579,226	-	2,579,226	2,612,640
Physician Compensation - Acute	4,471,583	5,070,089	3,955,851	-	-	-	-
Supportive Care Services	31,510,313	31,740,419	30,297,700	1,305,824	-	1,305,824	1,383,901
Home Based Service - Supportive Care	5,792,865	5,640,721	5,473,246	17,122	29,396	46,518	21,802
Population Health Services	3,068,829	2,871,566	2,815,665	22,636	-	22,636	26,080
Community Care Services	4,983,560	4,707,472	4,611,882	-	-	-	1,670
Home Based Services - Acute & Palliative	1,047,677	1,017,824	946,696	-	-	-	-
Primary Health Care Services	1,368,458	1,198,072	1,175,321	20,291	-	20,291	19,649
Emergency Response Services	2,203,529	2,242,591	2,151,155	1,603	-	1,603	10,019
Mental Health Services	1,992,770	2,037,538	1,899,338	-	-	-	-
Addictions Services	747,027	778,126	721,372	18,505	-	18,565	2,112
Physician Compensation - Community	1,612,402	1,678,687	1,610,809	-	-	-	-
Program Support Services	3,080,581	3,855,297	3,247,466	-	-	-	-
Special Funded Programs	826,237	769,351	745,943	-	-	-	-
Ancillary	145,397	141,913	133,060	-	-	-	-
Total Expenses (Schedule 1)	100,103,331	100,876,333	96,652,019	3,965,209	29,396	3,994,605	4,079,893
Excess (Deficiency) of revenues over expenses	$ 5,143	1,715,029	411,526	(1,693,358)	18,946	(1,674,412)	(2,317,889)
Fund Balances, beginning of year		1,227,902	1,227,902	26,041,612	1,585,036	27,127,448	29,033,811
Interfund transfers (Note 14)		(1,715,029)	(411,526)	1,717,603	(2,574)	1,715,029	411,526
Fund balances, end of year		$ 1,227,902	$ 1,227,902	$ 26,066,057	$ 1,102,009	$ 27,168,065	$ 27,127,448

See accompanying notes to the Financial Statements

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Statement 3

FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year Ended March 31, 2007

	Operating Fund		Restricted Fund			
	2007	2006 (Note 10)	Capital Fund	Community Trust Fund	Total 2007	Total 2006 (Note 10)
Cash Provided by (used in):	Operating Activities		Financing and Investing Activities			
Excess (deficiency) of revenue over expenses	$ 1,715,029	$ 411,526	$ (1,693,358)	$ 18,946	$ (1,674,412)	$ (2,317,889)
Net change in non-cash working capital (Note 7)	908,406	340,779	8,520	50,075	58,595	433,895
Amortization of capital assets	-	-	3,756,881	-	3,756,881	3,832,084
Investment income on long-term investments	-	-	-	-	-	-
Gain/(loss) on disposal of capital assets	-	-	-	-	-	-
	2,623,435	752,305	2,072,043	69,021	2,141,064	1,948,090
Purchase of capital assets						
Buildings/construction	-	-	(2,307)	-	(2,307)	(771,244)
Equipment	-	-	(612,343)	-	(612,343)	(3,007,114)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	-	-	-	-
Purchase of long-term investment	(5,597)	(62,000)	(165,768)	(185,168)	(350,936)	(547,873)
	(5,597)	(62,000)	(780,418)	(185,168)	(965,586)	(4,326,231)
Repayment of debt	-	-	(92,366)	-	(92,366)	(85,306)
Net increase (decrease) in cash & short term investments during the year	2,617,838	690,305	1,199,259	(116,147)	1,083,112	(2,463,447)
Cash & short term investments, beginning of year	10,585,843	10,307,064	3,953,474	354,996	4,308,470	6,360,391
Interfund transfers (Note 14)	(1,715,029)	(411,526)	1,717,603	(2,574)	1,715,029	411,526
Cash & short term investments, end of year (Schedule 2)	$ 11,488,652	$ 10,585,843	$ 6,870,336	$ 236,275	$ 7,106,611	$ 4,308,470
Amounts in cash balances						
Cash & short term investments	$ 11,488,652	$ 10,585,843	$ 6,870,336	$ 236,275	$ 7,106,611	$ 4,308,470

See accompanying notes to the Financial Statements

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FIVE HILLS REGIONAL HEALTH AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS
As At March 31, 2007

1. Legislative Authority

On August 1, 2002, the Legislative Assembly passed *The Regional Health Services Act* (The Act). The Act created the Regional Health Authorities for the purpose of governing the delivery of health services as well as establishing and governing Health Regions in the province of Saskatchewan. The Five Hills Regional Health Authority was created by the Act. The Five Hills Regional Health Authority (RHA) is responsible for the planning, organization, delivery, and evaluation of health services it is to provide within the geographic area known as the Five Hills Health Region.

The Five Hills Regional Health Authority is a non-profit organization and is not subject to income and property taxes from the federal, provincial and municipal levels of government.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles and include the following significant accounting policies.

a) Health Care Organizations

i) The RHA has agreements with and grants funding to the following CBOs and third parties to provide health services:

Extendicare (Canada) Inc.
Moose Jaw Alcohol and Drug Abuse Society Inc.
Canadian Mental Health Association (Saskatchewan Division)
Thunder Creek Rehabilitation Association Inc.
Lifeline Ambulance Service Inc.
Wald Ambulance Ltd.

Note 9 b) i) provides disclosure of payments to CBOs and third parties.

ii) The following affiliates are incorporated as follows (and are registered charities under the Income Tax Act):

Providence Place for Holistic Health Inc. - Non profit Corporations Act
St. Joseph's Hospital (Grey Nuns) of Gravelbourg – Non profit Corporations Act

The RHA provides annual grant funding to these organizations for the delivery of health care services. Consequently, the RHA has disclosed certain financial information regarding these affiliates.

Note 9 b) ii) provides supplementary information on the financial position, results of operations, and cash flows of the affiliates.

b) Fund Accounting

The accounts of the RHA are maintained in accordance with the restricted fund method of accounting for contributions. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the RHA including revenues received for provision of health services from Saskatchewan Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries, and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the RHA in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received from Saskatchewan Health - General Revenue Fund designated for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

iii) Community Trust Fund

The community trust fund is a restricted fund that reflects community generated assets transferred to the RHA in accordance with the pre-amalgamation agreements signed with the amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations in the RHA from donations or municipal tax levies. These assets are accounted for separately and use of the assets is subject to restrictions set out in pre-amalgamation agreements between the RHA and the health corporations.

c) Revenue

Unrestricted contributions are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Restricted contributions related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted contributions are recognized as revenue of the appropriate restricted fund in the year.

d) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Buildings	2.5 to 6.67%
Land improvements	2.5 to 20%
Equipment	5 to 33%

Donated capital assets are recorded at their fair value at the date of contribution (if fair value can be reasonably determined.)

e) Inventory

Inventory consists of general stores, pharmacy, laboratory, linen and other. Cost of inventory held is determined on a weighted average basis, except for dietary, linen, laundry, plant maintenance and remote facility inventory which is determined on a first in, first out basis.

f) Investments

Investments are valued at the lower of cost or market.

g) Pension

Employees of the RHA participate in several multi-employer defined benefit pension plans or a defined contribution plan. The RHA follows defined contribution plan accounting for its participation in the plans. Accordingly the RHA expenses all contributions it is required to make in the year.

h) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian generally accepted accounting principles. In the preparation of financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates and assumptions will occur based on the passage of time and the occurrence of certain future events. The changes will be reported in the period in which they become known.

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3. Capital Assets

	March 31, 2007			March 31, 2006
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Land	$ 266,556	$ -	$ 266,556	$ 266,556
Land Improvements	411,322	319,263	92,059	114,756
Buildings	39,690,732	24,870,149	14,820,583	16,629,913
Equipment	25,183,092	19,603,527	5,579,565	6,890,405
Construction in progress	17,646		17,646	17,010
	$ 65,569,348	$ 44,792,939	$ 20,776,409	$ 23,918,640

4. Commitments

a) Capital Assets Acquisitions

At March 31, 2007, commitments for acquisition of capital assets were $347,881 (2006 - $130,286).

5. Mortgages Payable

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2007	2006
Pioneer Housing (Moose Jaw) CMHC, due November 1, 2016	5.38%	$22,877 principal & interest Mortgage renewal date – November 1, 2016	$172,638	$183,951
Pioneer Housing (Moose Jaw) CMHC, due July 1, 2019	6.88%	$7,229 principal & interest Mortgage renewal date – July 1, 2019	60,301	63,330
Pioneer Housing (Moose Jaw) CMHC, due September 1, 2027	10.50%	$95,747 principal & interest of which $22,188 is subsidized by SHC Yielding an effective interest rate of 7.3% Mortgage renewal date - September 1, 2027	817,397	828,509
Regency Manor CMHC, due August 1, 2019	4.37%	$99,558 principal & interest of which $23,283 is subsidized by SHC Yielding an effective interest rate of 0% Mortgage renewal date - October 1, 2016	954,727	1,009,045
Assiniboia Pioneer Lodge CMHC, due October 1, 2024	8.00%	$6,503 principal & interest Mortgage renewal date - October 1, 2024	61,796	63,368
Assiniboia Pioneer Lodge CMHC, due October 1, 2024	6.00%	$18,561 principal & interest Mortgage renewal date - November 1, 2018	156,039	165,060
			$2,222,898	$2,315,263
Less: Current portion			100,033	99,542
			$2,122,865	$2,224,721

For each of the mortgages, the RHA has pledged the related buildings of the special care homes as security. Principal repayments required in each of the next five years is estimated as follows.

2008	$ 100,033
2009	108,361
2010	117,409
2011	127,242
2012	137,928
2013 and subsequent	1,631,924

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6. Deferred Revenue

	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Sask Health Initiatives				
Saskatchewan Health – General Revenue Fund	$ -	$ -	$ -	$ -
On site Emergency Room Medical Remuneration	8,444	-	9,115	17,559
Work Place Wellness	309,885	-	14,563	324,448
Successful Moms	49,952	2,789	-	47,163
Family Support and Rehab	67,999	-	4,576	72,575
Surgical Access	48,267	-	-	48,267
CT Evaluation	16,110	-	-	16,110
Diabetes Control	60,154	35,270	-	24,884
Nursing Council	49,046	16,876	-	32,170
Alt Physician Pymt C Butte	44,345	-	2,913	47,258
Alt Phys Pymt Teen Wellness	460	-	38	498
Substance Abuse Youth Needs	5,250	-	-	5,250
Professnl Development Fund	39,146	-	38,569	77,715
Needle Exchange	35,778	1,185	-	34,593
Undesig Medical Remuneration	186,205	-	-	186,205
Population Health Strategy	11,783	3,955	-	7,828
Primary Health Care Transition	1,714	1,714	-	-
Primary Health Care Team Facilitator	29,310	-	1,396	30,706
Primary Health Care Central Butte Site	318,710	-	98,251	416,961
Primary Health Care Assiniboia Kincaid	96,572	45,186	-	51,386
Quality Health Workplace Init	22,000	22,000	-	-
Renal Dialysis Project	86,859	-	-	86,859
Smoke Free Legislation	12,314	-	-	12,314
Mental Health Clinical Conf	10,000	10,000	-	-
JJE Funding	43,091	43,091	-	-
HIPA Implementation	10,070	-	-	10,070
Aboriginal Awareness Training	6,090	-	1,077	7,167
SIMS/PHIS	11,996	1,593	-	10,403
Health Line	-	-	3,324	3,324
Home Care Acute Initiative	11,967	11,967	-	-
Project Hope Cross Training	50,000	-	14,875	64,875
Project Hope	2,500	-	86,954	89,454
Project Hope Secure Youth Detox	-	-	31,577	31,577
Public Health Capacity	54,840	-	35,500	90,340
West Nile Virus	2,484	-	-	2,484
Prevention & Support	-	-	6,000	6,000
CTAS	-	-	12,116	12,116
Infection Control	-	-	150,000	150,000
MDS Home Care	-	-	73,580	73,580
Surgical Waitlist Incentive	65,000	-	62,596	127,596
Total Sask Health	**$ 1,768,341**	**$ 195,626**	**$ 647,020**	**$ 2,219,735**

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Non Sask Health Initiatives	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Sask Learning - General Revenue Fund - Kids First Targeted	$ 104,658	$ -	$ 29,995	$ 134,653
Sask Learning - General Revenue Fund - Kids First Non Targeted	23,809	14,080	-	9,729
Other - Special Needs	140,073	-	50,154	190,227
Other - SGI Acquired Brain Injury Prov Coord Adv	20,439	-	818	21,257
Other - SGI Acquired Brain Injury Prov Coord	-	-	3,307	3,307
Other - SGI Acquired Brain Injury Comm Coord Adv	14,773	-	3,427	18,200
Other - SGI Acquired Brain Injury Comm Coord	-	-	4,215	4,215
Other - Resource Centre	37,485	790	-	36,695
Mental Health Clinical Conference	23,910	5,329	-	18,581
Other - MJ Health Foundation	20,072	-	-	20,072
Other - Assiniboia Union Hospital	-	-	25,000	25,000
Other - Crark Health Centre	-	-	51,665	51,665
Other - Home Care Palliative	-	-	23,681	23,681
Other - First Nations Health Employer Support	-	-	25,000	25,000
Other - Pioneer Housing MJ Mortlach Mgmt Board	19,916	12,580	-	7,336
Other - miscellaneous	30,521	19,357	-	11,164
Total Non Sask Health	**$ 435,656**	**$ 52,136**	**$ 217,262**	**$ 600,782**
Total Deferred Revenue	**$ 2,203,997**	**$ 247,762**	**$ 864,282**	**$ 2,820,517**

7. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
	2007	2006	Capital Fund	Community Trust Fund	Total 2007	Total 2006
(Increase) Decrease in accounts receivable	$ 2,226,534	$ (2,548,456)	$ 9,895	$ 50,075	$ 59,970	$ 434,335
(Increase) Decrease in inventory	(24,388)	14,360			-	
(Increase) Decrease in prepaid expenses	(247,534)	(225,139)			-	
Increase (Decrease) in accounts payable	(643,146)	1,804,848	(1,375)		(1,375)	(440)
Increase (Decrease) in accrued salaries	(1,423,401)	1,308,077			-	
Increase (Decrease) in vacation payable	403,821	429,206			-	
Increase (Decrease) in deferred revenue	616,520	(442,117)			-	
	$ 908,406	$ 340,779	$ 8,520	$ 50,075	$ 58,595	$ 433,895

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8. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2007 was $3,771 (2006 - $3,624) and are included in the financial statements.

9. Related Party Transactions and Other Third Party Contractors

These financial statements include transactions with related parties. The RHA is related to all Saskatchewan Crown Agencies such as departments, corporations, boards and commissions under the common control of the Government of Saskatchewan. The RHA is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the RHA is related to other non-Government organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts resulting from these transactions are included in the financial statements at the standard rates charged by those organizations and are settled on normal trade terms.

In addition, the RHA pays Provincial Sales Tax to the Saskatchewan Department of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2007	2006
Revenues		
Workers Compensation	$ 211,567	$ 173,173
	$ 211,567	$ 173,173
Expenses		
Saskatchewan Association of Health Organizations	$ 2,513,339	$ 2,491,787
Saskatchewan Health Employees Pension Plan	2,738,463	2,681,062
Saskatchewan Health Information Network	-	390,714
Saskatchewan Energy	305,430	294,745
Saskatchewan Power	698,476	616,943
Saskatchewan Property Management	418,602	427,334
Sask Tel	240,223	233,204
Valleyview	624,697	595,440
Workers Compensation	1,100,186	1,137,282
	$ 8,639,416	$ 8,871,511

	2007	2006
Prepaid Expenditures		
Workers Compensation	$ 298,168	$ 264,654
Saskatchewan Association of Health Organizations	113,620	107,580
	$ 411,788	$ 372,234
Accounts Payable		
Saskatchewan Association of Health Organizations	$ 227,748	$ 159,950
Saskatchewan Health Employees Pension Plan	713,428	458,722
Saskatchewan Health Information Network	-	390,714
	$ 941,176	$ 1,009,386

b) Health Care Organizations

i) Community Based Organizations and Third Parties

The RHA has also entered into agreements with CBOs and Third Parties to provide health services.

These organizations receive operating funding from the RHA on a monthly basis in accordance with budget amounts approved annually. During the year, the RHA provided the following amounts to CBOs and Third Parties:

	2007	2006
Extendicare (Canada) Inc.	$ 5,002,825	$ 4,734,841
Moose Jaw Alcohol and Drug Abuse Society Inc.	778,126	721,972
Canadian Mental Health Association	11,050	10,000
Thunder Creek Rehabilitation Association Inc.	367,151	357,080
Lifeline Ambulance Service Inc.	1,182,570	1,140,485
Wald Ambulance Ltd.	460,304	464,940
	$ 7,802,026	$ 7,429,318

ii) Affiliates

The Act makes the RHA responsible for the delivery of health services in its region including the health services provided by privately owned affiliates. The Act requires affiliates to conduct their affairs and activities in a manner that is consistent with, and that reflects, the health goals and objectives established by the RHA. The RHA

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exercises significant influence over affiliates by virtue of its material inter-entity transactions. There is also an interchange of managerial personnel, provision of human resource and finance/administrative functions with some affiliates. The following presentation discloses the amount of funds granted to each affiliate:

	2007	2006
Providence Place for Holistic Health Inc.	$ 10,341,197	$ 9,692,123
St. Joseph's Hospital (Grey Nuns) of Gravelbourg	3,689,788	3,535,203
St. Joseph's Hospital (Grey Nuns) of Gravelbourg – Ambulance Service	200,001	162,667
	$ 14,230,986	$ 13,389,993

Saskatchewan Health requires additional reporting in the following financial summaries of the affiliate entities for the years ended March 31, 2007 and 2006.

	Total 2007	*Total 2006*
Balance Sheet		
Assets	*$3,560,266*	*$3,332,371*
Net Capital Assets	*26,847,386*	*27,715,135*
Total Assets	*$30,407,652*	*$31,047,506*
Total Liabilities	*$3,770,179*	*$3,171,608*
Total Net Assets	*26,637,473*	*27,875,898*
	$30,407,652	*$31,047,506*

	Total 2007	*Total 2006*
Results of Operations		
RHA Grant	*$13,982,982*	*$13,434,163*
Other Revenue	*4,018,319*	*3,880,318*
Total Revenue	*$18,001,301*	*$17,314,481*
Salaries & Benefits	*$13,737,125*	*$14,129,250*
*Other Expenses**	*5,189,939*	*4,097,880*
Total Expenses	*$18,927,064*	*$18,227,130*
Excess Revenue over Expenses	*($925,763)*	*($912,649)*

** Other Expenses includes amortization of $1,156,352 (2006-$1,166,877)*

	Total 2007	*Total 2006*
Cash Flows		
Cash from Operations	*$23,519*	*$244,981*
Cash used in financing activities	*208,735*	*116,132*
Cash used in Investing activities	*(255,282)*	*(352,152)*
Increase in cash	*($23,028)*	*$8,961*

iii) Fund Raising Foundations

Fund raising efforts are undertaken through a non-profit business corporation known as the Moose Jaw Health Foundation (the Foundation). The Five Hills RHA has an economic interest in the Foundation. In 2006 and in accordance with donor-imposed restrictions, $575,320 (2005 - $298,843) of the foundation's net assets must be used to purchase specialized equipment. In 2006, the foundation's total expenses include contributions of $320,652 (2005 - $279,387) to the RHA/community.

10. Comparative Information

Certain 2005-06 balances have been reclassified to conform with the current year's presentation.

11. Pension

Employees of the RHA participate in one of the following pension plans:

1. Saskatchewan Healthcare Employees' Pension Plan (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Saskatchewan Association of Health Organizations (SAHO) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multiemployer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the SAHO Board of Directors).

2. Public Service Superannuation Plan (a related party) - This is also a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. Public Employees' Pension Plan (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to the plans is limited to making required payments to match amounts contributed by employees for current services. Pension expense for the year amounted

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to $2,888,429 (2006 - $2,815,359) and is included in benefits in Schedule 1.

12. Budget

The RHA Board approved the 2006-2007 budget plan on May 31, 2006.

13. Financial Instruments

a) Significant terms and conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Credit risk

The RHA is exposed to credit risk from the potential non-payment of accounts receivable. The majority of the RHAs receivables are from Saskatchewan Health - General Revenue Fund, Saskatchewan Workers' Compensation Board, health insurance companies or other Provinces. Therefore, the credit risk is minimal.

c) Fair value

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

- The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature.

  cash and short term investments
  accounts receivable
  accounts payable
  accrued salaries and vacation payable

- For investments, the fair value is considered to approximate quoted market values.

- The fair value of mortgages and term loan payable before the repayment required within one year, is $2,178,879 (2006 - $2,433,564) and is determined using discounted cash flow analysis based on current incremental borrowing rates for similar borrowing arrangements.

14. Interfund Transfers

Each year the RHA transfers amounts between its funds for various purposes. These include funding capital asset purchases, and reassigning fund balances to support certain activities.

	2007			2006		
	Operating Fund	Capital Fund	Community Trust Fund	Operating Fund	Capital Fund	Community Trust Fund
Building renovations	$ -	$ -	$ -	$ -	$ -	$ -
Capital asset purchases	(1,659,896)	1,662,470	(2,574)	(354,207)	354,207	-
SHC reserves	(55,133)	55,133	-	(57,319)	57,319	-
Mortgage payments	-	-	-	-	-	-
Other	-	-	-	-	-	-
	$ (1,715,029)	$ 1,717,603	$ (2,574)	$ (411,526)	$ 411,526	$ -

15. Volunteer Services

The operations of the RHA utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

16. Contingent Liability

Joint Job Evaluation Reconsiderations

The joint job evaluation/pay equity initiative for the service provider unions CUPE, SEIU, and SGEU allowed for an appeal process. As a result, employees and employers have filed reconsideration appeals that are currently under review. A financial obligation to pay reconsideration costs occurs once the Steering Committee reviews the recommendations from the Reconsideration Committee and reaches a consensus decision. At this time there are outstanding reconsiderations on which the Steering Committee has yet to reach a final decision. The results of outstanding reconsiderations are currently unknown therefore, the cost of these reconsiderations cannot be reasonably determined.

17. Future accounting policy changes

The Canadian Institute of Chartered Accountants has issued new accounting standards including Section 3855, Financial Instruments - Recognition and Measurement. These standards will be effective on April 1, 2007. Under the new standard, all financial instruments will be classified as one of the following: held to maturity, loans and receivables, held for trading, available for sale or other liabilities.

Financial assets and liabilities held for trading will be measured at fair value with gains and losses recognized in excess of revenues over expenses. Financial assets held to maturity, loans and receivables and financial liabilities other than those held for trading, will be measured at amortized cost. Available for sale instruments will be measured at fair value with unrealized gains and losses recognized in net assets. The standards also permit designation of any financial instrument as held for trading upon initial recognition.

The estimated impact to net assets effective April 1, 2007 as a result of applying the new financial instruments accounting standards will not be significant.

Schedule 1

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENSES
For the Year Ended March 31, 2007

	Budget 2007	Actual 2007	Actual 2006
Operating:			
Board costs	$ 118,924	$ 82,417	$ 73,221
Compensation - Benefits	8,718,607	8,835,640	9,073,511
Compensation - Salaries	48,248,561	48,390,491	46,617,935
Diagnostic imaging supplies	309,056	262,578	280,992
Drugs	1,495,221	1,298,627	1,351,967
Food	982,635	989,247	947,773
Grants to ambulance services	1,895,812	1,884,200	1,809,817
Grants to third parties	19,857,895	20,196,836	19,102,973
Housekeeping and laundry supplies	369,305	378,163	353,584
Information technology contracts	278,095	209,720	188,277
Insurance	218,165	198,229	195,463
Interest	2,677	1,781	771
Laboratory supplies	866,120	761,804	822,794
Medical and surgical supplies	1,871,817	1,790,128	1,660,676
Medical remuneration and benefits	6,024,923	6,481,971	5,480,446
Office supplies and other office costs	406,932	389,634	386,494
Other	892,260	952,763	738,981
Other referred out services	1,189,703	1,241,759	1,296,930
Professional fees	479,812	623,326	862,279
Prosthetics	616,811	547,115	569,600
Purchased services	787,171	520,765	356,919
Rent/lease costs	870,579	921,661	870,018
Repairs and maintenance	598,205	651,448	703,433
Service contracts	633,316	664,863	594,974
Travel	836,695	1,122,466	899,597
Utilities	1,536,034	1,478,701	1,412,594
	$ 100,105,331	$ 100,876,333	$ 96,652,019
Restricted:			
Amortization		$ 3,756,881	$ 3,832,084
Loss/(Gain) on disposal of fixed assets		-	-
Other		237,724	243,809
		$ 3,994,605	$ 4,075,893

Schedule 2

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF INVESTMENTS
For the Year Ended March 31, 2007

	Amount	Maturity	Effective Rate	Coupon Rate
Restricted Investments*				
Cash and Short Term				
Chequing and Savings:				
Concentra	$ 7,074,768			
RBC Dominion Securities	20,243			
	$ 7,095,011			
Bond/Mutual Fund:				
Province of Saskatchewan	$ 11,600	7/15/2007	4.00%	4.00%
Total Cash & Short Term Investments	$ 7,106,611			
Long Term				
Ontario Hydro	$ 67,616	6/2/2008	4.49%	4.49%
Home Trust Company	83,084	2/23/2009	4.26%	4.26%
ICICI Bank	83,084	2/23/2009	4.27%	4.27%
Province of Quebec	133,968	6/1/2009	3.93%	3.93%
Province of Saskatchewan	115,100	7/15/2010	4.00%	4.00%
Royal Bank CPI Notes	520,000	12/5/2012	3.71%	3.71%
Province of British Columbia	357,839	8/23/2013	8.50%	6.81%
Province of British Columbia	62,400	8/23/2013	3.90%	3.90%
Ontario Hydro	42,976	8/18/2022	8.90%	8.90%
Total Long Term Investments	$ 1,466,067			
Total Restricted Investments	$ 8,572,678			
Unrestricted Investments				
Cash and Short Term				
Chequing and Savings:				
Concentra	$ 11,473,633			
Royal Bank	3,375			
RBC Dominion Securities	99			
Cash on hand	8,245			
	$ 11,485,352			
Bond/Mutual Fund:				
Province of Saskatchewan	$ 3,300	7/15/2007	4.00%	4.00%
Total Cash & Short Term Investments	$ 11,488,652			
Long Term				
Ontario Hydro	$ 8,225	6/2/2008	4.49%	4.49%
Province of Nova Scotia	8,899	6/1/2009	3.80%	3.80%
Province of Saskatchewan	62,000	7/15/2010	4.00%	4.00%
Total Long Term Investments	$ 79,124			
Total Unrestricted Investments	$ 11,567,776			
Total Investments	$ 20,140,454			
Restricted & Unrestricted Totals				
Total Cash & Short Term	$ 18,595,263			
Total Long Term	$ 1,545,191			
Total Investments	$ 20,140,454			

*Restricted Investments consist of community generated funds transferred to the RHA and held in the Community Trust Fund (Schedule 3), and replacement reserves maintained under mortgage agreements with the Canada Mortgage and Housing Corporation (CMHC) and/or Saskatchewan Housing Corporation (an agency of the Department of Community Resources and Employment) (SHC) are held in the Capital Fund (Schedule 4).

Schedule 3

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2007

COMMUNITY TRUST FUND EQUITY

Trust Name	Balance Beginning of Year	Investment & Other Revenue	Donation	Expenses	Withdrawals	Balance End of Year
Moose Jaw Union Hospital - Haggerty	$ 81,179	$ 3,462	$ -	$ -	$ -	$ 84,641
Moose Jaw Union Hospital - Elsom/Mutrie	12,750	586	-	-	-	13,336
Craik Health Centre	115,199	4,928	-	-	-	120,127
Thunder Creek Home Care	875,623	39,328	-	(29,396)	(2,574)	882,981
South Country	885	38	-	-	-	923
Total Community Trust Fund	**$ 1,085,636**	**$ 48,342**	**$ -**	**$ (29,396)**	**$ (2,574)**	**$ 1,102,008**

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Schedule 4

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY RESTRICTED FUND BALANCES
For the Year Ended March 31, 2007

	Balance Beginning of Year	Investment Income Allocated	Annual Allocation (from unrestricted funds)	Operating Expenses	Capital Expenses	Balance End of Year
Capital						
SHC Replacement Reserves						
Assiniboia Pioneer Lodge	$ 160,412	$ 7,230	$ 23,866	$ -	$ -	$ 191,508
Pioneer Housing - Lodge (Moose Jaw)	153,453	6,750	14,833	-	-	175,036
Pioneer Housing - Units (Moose Jaw)	170,639	7,350	12,000	(3,215)	-	186,774
Regency Manor	111,320	4,830	7,650	-	-	123,800
Total SHC	595,824	26,160	58,349	(3,215)	-	677,118
Other Internally Restricted Funds						
LaFleche Health Centre Roof - SGI	23,884	-	-	-	-	23,884
Total Capital	$ 619,708	$ 26,160	$ 58,349	$ (3,215)	$ -	$ 701,002
Operating						
Other Internally Restricted Funds						
Elder Care Study	$ 56,629	$ -	$ -	$ (50,836)	$ -	$ 5,793
Total Operating	$ 56,629	$ -	$ -	$ (50,836)	$ -	$ 5,793
Total Internally Restricted Funds	$ 676,337	$ 26,160	$ 58,349	$ (54,051)	$ -	$ 706,795

The RHA is required to maintain certain replacement reserves as a condition of receiving subsidy assistance from Saskatchewan Housing Corporation.

The above schedule shows the changes in these reserve balances during the year.

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Schedule 5

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULES OF
BOARD REMUNERATION, BENEFITS AND ALLOWANCES
For the Year Ended March 31, 2007

RHA MEMBERS	RETAINER	PER DIEM	TRAVEL TIME EXPENSES	TRAVEL AND SUSTENANCE EXPENSES	OTHER EXPENSES	CPP	2007 TOTAL	2006 TOTAL
Dale Tom	9,960	7,463		418	1,116	732	19,689	20,813
							-	
Alvin Arnold [1]		3,150	850	1,494	251		5,745	-
John Bumbac		6,675	1,770	2,793	541		11,779	14,405
Marian Campbell		4,175	413	679	713	98	6,078	7,050
Shayne Cristo [2]		2,800	1,131	1,816	272	92	6,111	
Joanne Dusel		4,975	450	720	839	138	7,122	3,907
Leslie Gray		5,125	175	381	975		6,656	8,031
Richard Kurz [3]		-					-	775
Betty Michalski		4,800		185	691		5,676	5,514
Elaine Mulatz		4,838		192	268	96	5,394	6,190
Janeth Muldoon [4]		3,463	1,125	1,623	672	112	6,995	-
Donald Shanner [5]		3,300			298	52	3,650	-
Donna Stang		3,050	150	1,134	321	64	4,719	6,550
Louise Walker [6]		-					-	3,138
TOTAL	9,960	53,814	6,064	11,435	6,957	1,384	89,614	76,373

(1) appointed June 22, 2006
(2) appointed June 22, 2006
(3) Resigned June 22, 2005
(4) appointed June 22, 2006
(5) appointed June 22, 2006
(6) Resigned June 30, 2005

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES AND SEVERANCE
For the Year Ended March 31, 2007

	2007					2006		
Senior Employees	Salaries[1]	Benefits and Allowances[2]	Sub-total	Severance Amount	Total	Salaries, Benefits & Allowances[1,2]	Severance	Total
Dan Florizone, CEO	$ 161,802	$ 5,110	$ 166,912	$ -	$ 166,912	$ 138,844	$ -	$ 138,844
Craig Heisler, Exec Dir	107,601	-	107,601	-	107,601	101,802	-	101,802
Cheryl Craig, Exec Dir	114,674	-	114,674	-	114,674	109,715	-	109,715
Nola Avery, Exec Dir	100,254	-	100,254	-	100,254	35,320	-	35,320
Wayne Blaschko, Exec Dir & CFO	110,422	-	110,422	-	110,422	111,906	-	111,906
Dr. Mark Vought, MHO	193,228	-	193,228	-	193,228	188,762	-	188,762
Tom Hutchinson, Exec Dir	99,008	-	99,008	-	99,008	92,453	-	92,453
Duane Ferguson, Exec Dir	99,008	-	99,008	-	99,008	87,984	-	87,984
Dr. Tyronne Tostad, Medical Director	115,451	-	115,451	-	115,451	103,843	-	103,843
John Logan, Exec Dir	99,008	-	99,008	-	99,008	92,061	-	92,061
Gillian Linklater, Exec Dir	58,607	-	58,607	-	58,607	-	-	-
Robert Hurlburt, Chief Human Resources	-	-	-	-	-	66,723	-	66,723
Total	$ 1,259,063	$ 5,110	$ 1,264,173	$ -	$ 1,264,173	$ 1,129,413	$ -	$ 1,129,413

1. Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave, and merit or performance pay, lumpsum payments and any other direct cash remuneration.
2. Benefits and Allowances include the employer's share of amounts paid for the employees' benefits and allowances that are taxable to the employee. This includes taxable professional development, education for personal interest, nonaccountable relocation benefits, personal use of an automobile, cell phone, computer etc. As well as any other taxable benefits.

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APPENDIX A

2006-07 PERFORMANCE RESULTS
NOTES IN SUPPORT OF MANDATORY INDICATORS

GOAL 1
IMPROVED ACCESS TO QUALITY HEALTH SERVICES

PERCENTAGE OF PRIORITY LEVEL I, II, III AND IV SURGICAL CASES COMPLETED WITHIN TARGET TIME FRAMES

The role of the Saskatchewan Surgical Care Network (SSCN) is to ensure a better, more equitable surgical care system for Saskatchewan people.

The SSCN Patient Assessment Process has been developed to consistently assess patients' level of need for surgery, and fairly place them on the waiting list.

This indicator shows the proportion of patients that have received their surgery within an appropriate time based on their condition and situation.

The Target Wait Times by Priority Level determined from the Patient Assessment Tool and Urgency Profiles for each procedure are as follows:

Priority Level	Urgency Score Range	Target Wait Time
Emergency		Managed Separately
Priority I	80 to 100	95% within 3 weeks
Priority II	65 to 79	90% within 6 weeks
Priority III	50 to 64	90% within 3 months
Priority IV	1 to 49	90% within 12 months
All Cases		Within 18 months

The Patient Assessment Tool produces an Assessment Score based on a patient's situation. The Assessment Score is combined with the Urgency Profile for the procedure to generate an Urgency Score. The Urgency Score determines the Priority Level of the patient. The Priority Level determines the Target Time Frame for surgery.

Surgical priority levels are defined at www.sasksurgery.ca/target_timeframes.htm.

The goal of Saskatchewan Health is to increase the volumes of medically necessary procedures where patients are waiting excessively long times for surgery, in addition to managing wait lists in a more efficient manner in order to reduce the maximum wait time.

The values of this indicator can be improved by using information from the surgical registry to order patients appropriately according to their level of urgency and the time that they have already waited for surgery.

When patients in Priority Level IV jump the queue and get their surgery within less than three months, they take the spot of an urgent patient who needed to have their surgery performed quickly. This queue jumping also causes other Priority Level IV patients to wait longer for surgery.

Managing patients to the Target Time Frames for Priority Levels I to III ensures that patients with an urgent need for surgery get done in a timely fashion.

For example, if surgeons that perform the same types of surgery can pool their patients so that the first available surgeon can treat the next longest waiting patient then maximum waits for surgery could be reduced. This would allow one queue rather than a separate queue for each surgeon. Another way of achieving the same effect would be for referrals to surgeons from the General Practitioners to be pooled so that patients are sent to surgeons with a shorter wait list.

CUMULATIVE NUMBER OF SURGICAL CASES PERFORMED AS A PERCENTAGE OF TARGET AND VARIANCE FROM TARGET

Each region has a target for the number of surgeries to be performed over the course of the fiscal year. This indicator shows whether this target was met or not.

Saskatchewan Health has agreements with the Regional Health Authorities (RHAs) regarding the volume of surgeries that they will provide each year.

Increasing the number of procedures performed in the day surgery setting frees up inpatient beds for other procedures that require a longer recovery time.

Knowing what is going on in the environment (i.e. the context) is also important in interpreting the results. For example, more day surgery may have been performed due to job action, shortage of inpatient beds, in order to meet certain targets, or because the region may have a larger proportion of cases that can be handled in the day surgery setting.

The goal of the Saskatchewan Surgical Care Network is to increase the volumes of medically necessary procedures where patients are waiting excessively long times for surgery, in addition to managing wait lists in a more efficient manner in order to reduce the maximum wait time.

The following actions may help to achieve the target number of surgeries.

- Investigate the possibility of moving inpatient cases with a short length of stay to the day surgery setting. This would help to free up inpatient beds for procedures that require an inpatient recovery time.
- Work towards smoothing the number of elective inpatient surgeries performed by each specialty on Monday to Friday. This helps to increase the likelihood of an appropriate bed being available post surgery. Patients who are located off service (e.g. a surgical patient in a medical bed) generally have a longer recovery time. This also would help to reduce bed shortages during the week by smoothing out the peaks in demand for beds. Resources currently devoted to finding beds for patients could be used for other tasks. Minimizing the number of times that a patient has to be moved can help to shorten their recovery time.
- Examine historical data to predict future demand for service. Take measures to smooth and predict elective/scheduled surgeries as these are the cases that we can control.
- Work towards improving patient safety. For example, steps taken to minimize post operative infections, medication errors, and prevention of falls can help to reduce the length of stay in hospital freeing up beds for other patients.
- Use multidisciplinary rounds to coordinate the care of patients, review patient status, schedule tests and procedures, clarify goals, identify safety risks, and create a plan for the day. This helps to ensure better clinical outcomes, timely discharges and patient and staff satisfaction.
- Work with community health services such as long-term care facilities and home care to ensure timely and smooth discharges from the acute care setting and to avoid readmissions to hospital.
- Look for methods of optimizing patient flow on the day of surgery and reducing the number of cases that are postponed. This may allow for a few more cases to be done in the course of the day.

AVERAGE WAIT TIME FOR ADMISSION TO ALCOHOL AND DRUG OUTPATIENT SERVICES

Temporal access or waiting time is an important dimension of accessibility. Delays in service can result in harm to persons exhibiting alcohol and drug addiction and their families as well as discouraging future treatment seeking behaviour.

Contributing factors include:

- Service volumes.
- Social stability and support.
- Spousal and/or family support.

Calculation or Methodology Description

The total number of days wait from approval for admission to admission to an alcohol and drug services outpatient program for all clients registered for a specified time period (e.g. fiscal year) divided by the total number of clients receiving outpatient alcohol and drug services for that time period

AVERAGE WAIT TIME FOR ADMISSION TO ALCOHOL AND DRUG INPATIENT SERVICES

Temporal access or waiting time is an important dimension of accessibility. Delays in service can result in harm to persons exhibiting alcohol and drug addiction and their families as well as discouraging future treatment seeking behaviour.

Contributing factors include:

- Service volumes.
- Social stability and support.
- Spousal and/or family support.

Calculation or Methodology Description

The total number of days wait from approval for admission to admission to an alcohol and drug services inpatient program for all clients registered for a specified time period (e.g. fiscal year) divided by the total number of clients receiving inpatient alcohol and drug services for that time period.

AVERAGE WAIT TIME FOR ADMISSION TO ALCOHOL AND DRUG DETOXIFICATION SERVICES

Temporal access or waiting time is an important dimension of accessibility. Delays in service can result in harm to persons exhibiting alcohol and drug addiction and their families as well as discouraging future treatment seeking behaviour.

Contributing factors include:

- Service volumes.
- Social stability and support.
- Spousal and/or family support.

Calculation or Methodology Description

The total number of days wait from approval for admission to admission to an alcohol and drug services detoxification program for all clients registered for a specified time period (e.g. fiscal year) divided by the total number of clients receiving detoxification alcohol and drug services for that time period.

AVERAGE WAIT TIME FOR ADMISSION TO ALCOHOL AND DRUG STABILIZATION SERVICES

Temporal access or waiting time is an important dimension of accessibility. Delays in service can result in harm to persons exhibiting alcohol and drug addiction and their families as well as discouraging future treatment seeking behaviour.

Contributing factors include:

- Service volumes.
- Social stability and support.
- Spousal and/or family support.

Calculation or Methodology Description

The total number of days wait from approval for admission to admission to an alcohol and drug services stabilization program for all clients registered for a specified time period (e.g. fiscal year) divided by the total number of clients receiving stabilization alcohol and drug services for that time period.

PERCENTAGE OF RHA POPULATION WITH GEOGRAPHIC PROXIMITY TO PRIMARY HEALTH CARE TEAMS

December 2001 "Action Plan for Saskatchewan Health Care", the government committed to building a province of healthy people and healthy communities by improving the quality of services and access to care, while ensuring the health system is sustainable into the future. The "Action Plan" committed to the development of primary health care teams targeting access (to primary health care services) for 25% of Saskatchewan residents by 2006 and 100% of Saskatchewan residents by 2011.

The 2003 First Ministers' Accord (on health care renewal) maintains that the ultimate goal of primary health care reform in Canada is to provide all Canadians, wherever they live, with access to an appropriate health care provider, 24 hours a day, 7 days a week. Towards this goal, First Ministers emphasized accelerating primary health care initiatives and making significant annual progress so that citizens routinely receive needed care from interdisciplinary primary health care teams. The Accord committed to the goal of ensuring that at least 50% of residents have 24/7 access to a primary health care team within 8 years.

Primary Health Services Branch (PHSB) continues to guide and support the RHAs as they strive to establish new primary health care teams to serve the residents of their region. The following four indicators have been developed to measure Primary Health Services Branch's effectiveness in advancing primary health care reform throughout the province:

1. Percentage of RHA population with geographic proximity to primary health care teams;
2. Number of discrete patients receiving primary health care services in the RHA;
3. Number of persons receiving a service from the HealthLine for the RHA; and
4. Total number of new and/or expanded primary health care teams developed in the current year.

Together, these indicators will be able to paint a comprehensive picture of the various dimensions of primary health care access in the province.

Factors that may affect the indicators are:

- changes in patterns of care seeking;
- lack of or reduced (government) funding to the RHAs for the development and operation of their primary health care team(s);
- changes in RHA population distribution;
- changes in the rural economy;
- human resources – recruitment and retention of health care providers; and
- physician acceptance of alternate method of payment (as opposed to fee-for-service).

The continuous increase in the percentage of population with geographic proximity to primary health care teams is a reflection of PHSB's efforts and support to the RHAs as primary health care advances throughout the province.

Calculation or Methodology Description

To determine geographic proximity to a primary health care (PHC) team, a RHA primarily considers patterns of care seeking data. Because of Saskatchewan's diverse geography, other factors such as trading patterns, transportation routes and travel distances are also considered when making these determinations.

When determining the number of residents within close geographic proximity to a primary health care team, consideration is given to the fact that there may be overlap with other primary health care teams in the vicinity. When this is the case, neighbourhoods/communities are apportioned based on the location of other primary health care teams nearby.

* Discrete patients are the patients that sought the services of the primary heath care team within the RHA. Patients are only counted once by the primary health care team and the patient residence is not necessarily within the RHA.

** Covered Population includes all Saskatchewan residents that are eligible for health insurance benefits. Excluded are: (1) members of the Canadian Armed Forces, (2) members of the RCMP, (3) inmates in federal prisons, (4) people who have not been in the province for a minimum of 3 months. The Covered Population is based on a June 30th snapshot from Saskatchewan Health's Person Registry System (PRS), and is usually available in the fall of that same year.

NUMBER OF DISCRETE CLIENTS RECEIVING PRIMARY HEALTH CARE SERVICES IN THE RHA

Discrete patients are the patients that sought the services of the primary heath care team within the Regional Health Authority (RHA). Patients are only counted once by the team and the patient residence is not necessarily within the RHA.

The continuous increase in the number of discrete patients receiving primary health care services in the province is a reflection of Primary Health Services Branch's (PHSB's) efforts and support to the RHAs as primary health care advances throughout the province.

NUMBER OF HEALTHLINE CALLS FOR THE RHA

A registered call to Healthline is one in which a record is opened in order to triage a symptom based call in order to provide health information and advice. Additionally, a registered call may include callers who call for general health information / service information.

HealthLine is a key strategy to support Primary Health Care Teams and access to health information and advice to all residents of Saskatchewan. It is staffed 24 hours a day by Registered Nurses who provide advice and information to callers.

HealthLine was established in August 2003.

HealthLine is a viable solution to improve health care access for rural and remote populations.

The key objectives of the service in Saskatchewan are to:

- improve public access to safe, accurate and appropriate health information and advice;
- facilitate the use of the most appropriate health services by consumers;
- increase consumer health education and improve decision-making by consumers; and
- improve public satisfaction with:
  - access to quality health information; and
  - access to appropriate health services.

GOAL 2
EFFECTIVE HEALTH PROMOTION AND DISEASE PREVENTION

PERCENTAGE OF FACILITIES IN COMPLIANCE WITH THE TOBACCO CONTROL ACT IN THE CATEGORY THAT INCLUDES: BILLIARD HALLS / BINGO ESTABLISHMENTS / BOWLING CENTRES / CASINOS / RESTAURANTS / TAVERNS

Public health regulatory programs commonly use routine on-site inspections to determine compliance with regulations. While inspection frequencies vary among jurisdictions, Saskatchewan Health's longstanding objective has been to conduct at least one annual inspection of licensed facilities.

While most countries administer public safety and health regulations, there is very little research exploring the effectiveness and efficiency of routine inspection programs. However, because infractions and faulty practices are uncovered and remedied through the inspection process, it is reasonable to conclude that without such a program, infractions and practices will be left unattended resulting in increased risk smoking in enclosed public places.

Environmental tobacco smoke exposure increases the likelihood of lung cancer and respiratory disease in non-smokers. Smoking is a risk factor for heart disease and strokes. Environmental barriers to smoking such as banning smoking in enclosed public places may decrease the frequency of smoking in smokers.

Target is 90% compliance.

Inspections for *The Tobacco Control Act* will occur during routine inspection of facilities for other purposes (e.g. *The Public Health Act*). For those facilities not routinely inspected by public health inspectors, compliance will be monitored by responding to complaints. Any facilities not in compliance will be issued tickets. Tickets are an effective means of gaining and maintaining compliance.

The Tobacco Control Act also allows for ticketing of patrons. While not captured by this indicator, this is also an effective means to support and influence compliance in facilities.

GOAL 3
RETAIN, RECRUIT AND TRAIN HEALTH PROVIDERS

NUMBER OF SICK LEAVE HOURS PER FULL TIME EQUIVALENT (FTE) BY AFFILIATION

Work absence is the failure of employees to report for work when they are scheduled to work. Absence as a result of illness or injury (sick leave) is often used as a proxy measure for a healthy workplace. In the 2000 Canadian Labour and Business Centre Leadership Survey, business leaders and trade unions identified low absenteeism rates / high morale among the top five indicators of a healthy workplace. Absenteeism is one of the five "Quality of Work Life Indicators" identified by the Canadian Council on Health Services Accreditation (2002) (how CCHSA is defining absenteeism to be determined).

Statistics Canada Labour Force Survey indicates that those in health occupations are more likely than those in other sectors to miss work due to illness or disability. In 2000, on average, 7.2% of full-time workers in health occupations missed work each week due to illness or disability. This ranged from a low of 5.4% in Prince Edward Island to a high of 9.3% in Nova Scotia; Saskatchewan's rate was 8.0%. Professional nurses, who comprise the largest professional group of the health workforce in Saskatchewan, have the highest rate of absences of any occupation.

Absence from scheduled work is a "lagging" indicator. It reflects the cumulative impact of a wide range of workplace problems including psychological stress, low staff morale, and employee dissatisfaction.

Work absences reflect a wide range of workplace problems. If problems are not being addressed one should not expect to see changes in the rate.

As with many human resource indicators, benchmarks will have to be developed. In the interim, Regional Health Authorities (RHAs) and the Saskatchewan Cancer Agency (SCA) can use the provincial rates or those of the best performers as benchmarks.

Contributing factors include:

- Legitimate illness or injury. Some sources suggest 70% of workplace lost days are due to legitimate personal illness or injury.
- Rates of absenteeism are known to be higher in unionized workplaces than in non-unionized ones.
- Women are more frequently absent than men.
- As the workforce ages, the physical demands of the workplace take more of a toll on many groups of health care workers.
- Family pressures and personal work ethic influence the indicator.
- Generally, the higher the rate of pay and the greater the length of service of the employee, the fewer the absences.

NUMBER OF WAGE-DRIVEN PREMIUM HOURS (OVERTIME AND OTHER PREMIUMS) PER FULL TIME EQUIVALENT (FTE) BY AFFILIATION

Overtime, like absenteeism and high levels of Workers' Compensation Board (WCB) claims, may be indicative of a wide range of workplace problems. If problems are not being addressed one should not expect to see changes in the rate.

As with many human resource indicators, benchmarks will have to be developed. In the interim, RHAs and the SCA can use the provincial rates or those of the best performers as benchmarks.

Contributing factors include:

- In 24/7 work environments, management teams have to staff to the levels required to maintain the service.
- Rates of absenteeism.
- Availability of casual / replacement staff particularly in rural and remote settings.
- Collective agreements.
- Vacancies and hard to recruit professions.

NUMBER OF LOST-TIME WCB CLAIMS PER 100 FULL TIME EQUIVALENTS (FTEs)

In 2003, 7.2% of Saskatchewan's health sector workers had injuries that resulted in time away from work (up from 5.7% in 1999). Back and shoulder injuries were the most common. Employers are legally responsible for workplace safety, however, individuals must also do their part to keep themselves, their co-workers, and their patients safe.

All workplaces do not experience the same injury / illness rates. Average injury / illness rates differ in the various industry sectors as well as in same sector. Some sectors (such as health care) are more hazardous than others and therefore it seems natural that there will be higher injury rates in these. However, even among organizations engaged in similar businesses there is great variation in injury / illness rates. Even in higher risk business operations the most successful companies are achieving lost-time injury / illness rates under 0.5 per hundred employees, or six times better safety performance than the average. There are opportunities in all sectors for organizations to improve their performance.

In the private sector, businesses that have taken the initiative to prevent workplace injuries have one quarter or lower injury rates than competitors who have not. These organizations have implemented effective safety management systems not just because of concern for their employees, or for legal compliance, but because they understand that superior health and safety results leads to:

- lower costs;
- improved employee relations and employee trust;
- improved reliability and productivity;
- improved protection from business interruption;
- increased public trust and improved public image; and,
- increased organizational capability.

WCB suggests that this data is more suited to annual collection and explanation. The extremely volatile nature of injury makes quarterly or monthly comparisons difficult. Comparison between "frequency" (the number of claims made) and "severity" (the number of WCB days paid to employees) is not possible because they are concurrent but not fully interrelated events.

The Saskatchewan Provincial Auditor's Report for 2004 recommends that Regional Health Authorities set a 3-year target for reducing work-related injuries (Provincial Auditor Saskatchewan, p.72).

As with many human resource indicators, benchmarks will have to be developed. In the interim, Regional Health Authorities (RHAs) and the Saskatchewan Cancer Agency (SCA) can use the provincial rates or those of the best performers as benchmarks.

NUMBER OF LOST-TIME WCB DAYS PER 100 FULL TIME EQUIVALENTS (FTEs)

In 2003, 7.2% of Saskatchewan's health sector workers had injuries that resulted in time away from work (up from 5.7% in 1999). Back and shoulder injuries are common. Employers are legally responsible for workplace safety, however individuals must also do their part to keep themselves, their co-workers, and their patients safe.

A lost-time WCB day is defined as eight (8) hours.

WCB suggests that this data is more suited to annual collection and explanation. The extremely volatile nature of injury makes quarterly or monthly comparisons difficult. Comparison between "frequency" (the number of claims made) and "severity" (the number of WCB days paid to employees) is not possible because they are concurrent but not fully interrelated events.

As with many human resource indicators, benchmarks will have to be developed. In the interim, Regional Health Authorities (RHAs) and the Saskatchewan Cancer Agency (SCA) can use the provincial rates or those of the best performers as benchmarks.

Contributing factors include:

- Nature and severity of the injury.

GOAL 4
A SUSTAINABLE, EFFICIENT, ACCOUNTABLE, QUALITY HEALTH SYSTEM

KEY ACTIVITIES UNDERTAKEN BY RHA TO ADDRESS PUBLIC CONFIDENCE REPORTED

This measure indicates whether significant activity is taking place to address health region situations that affect public confidence (in current health services and the future direction of the health region or the health system), or to influence public opinion. It is a "yes/no" response to the statement "The Regional Health Authority (RHA) undertook significant activities this quarter to address public confidence". This would include public confidence in the health system generally, and in region-delivered services specifically (RHA -wide activities, not solely communications unit activities).

"Significant activities" would be any activities that take up a significant amount of staff time, and are clearly aimed at affecting the perceptions by members of the public of the health region or the health system. A planning process can be included as an activity.

Note: Health regions are expected to undertake a significant level of activity over the fiscal year. These activities are not expected to necessarily be reflected in activity during each quarter (it is okay to answer "no" in a given quarter, if health region priorities were elsewhere during that quarter).

PERCENTAGE OF SURGICAL CASES PERFORMED AS DAY SURGERY

Saskatchewan Health has agreements with Regional Health Authorities (RHAs) regarding the volume of surgeries that they will provide each year.

Volumes of surgeries do not tell the complete picture because some surgeries take fewer resources than others. Showing the inpatient versus day surgery breakdown goes some way to address this. Looking at surgical hours along with volumes may provide a better picture.

Increasing the number of procedures performed in the day surgery setting frees up inpatient beds for other procedures that require a longer recovery time.

Knowing what is going on in the environment (i.e. the context) is also important in interpreting the results. For example, more day surgery may have been performed due to job action, shortage of inpatient beds, in order to meet certain targets, or because the region may have a larger proportion of cases that can be handled in the day surgery setting.

Saskatchewan Health

Five Hills Regional Health Authority